

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

10431

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Burnham Rd.				d. STREET ADDRESS Burnham Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Yvonne Last Addison				4. DATE OF DEATH Month 10/19/56 Day 19 Year 19			
5. SEX female		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/56	
9. AGE (In years last birthday) yrs. 2 Months 2 Days 20		IF UNDER 1 YEAR Months 2 Days 20		IF UNDER 24 HRS. Hours 20 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dosey Addison				14. MOTHER'S MAIDEN NAME Doris Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Dorsey Addison (father) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475x DUE TO Conditions, if any, which gave rise to immediate cause (b) vomit (c) Upper Respiratory Infection DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH Found dead in bed ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct 29/56		22c. NAME OF CEMETERY OR CREMATORY Brook Grove Md		22d. LOCATION (City, town, or county) (State) Montgomery Co md	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Extonville		24a. REC'D BY REGISTRAR DATE Oct 23-56	
				24b. REGISTRAR'S SIGNATURE Abner L. Cord			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICIAN'S CERTIFICATE OF DEATH

BUREAU V. S.

1956 86 108

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Breinert Released body 5/10/56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10432

CERTIFICATE OF DEATH

10395

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 74 Suburban Hospital				d. STREET ADDRESS 7729 Brookville Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last JERRY William Bachman				4. DATE OF DEATH Month Day Year Oct 22 1956			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/31/01	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY Paint Store		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME FREDRICK Bachman				14. MOTHER'S MAIDEN NAME NEEDHAM, GRACE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 577-05-2737		17. INFORMANT Wife - Item #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Coronary Occlusion DUE TO 1 1/2 hr. (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bethesda Montgomery Md	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAR 31 , 19 56 , to Oct 22 , 19 56 , that I last saw the deceased alive on Oct 22 , 19 56 , and that death occurred at 9:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4630 Montgomery Ave Bethesda Md DATE SIGNED —							
ACTUAL SIGNATURE A. J. Breinert				M.D. 4630 Montgomery Ave Bethesda Md			
PHYSICIAN'S NAME (Type) A. J. BREINERT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md				24a. REC'D BY REGISTRAR DATE 10-24-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

1935

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		1900		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH	
1234 Main St.		Teacher		Heart Disease		Natural		Oct 25, 1935	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE	
Oct 25, 1935		Home		10:00 AM		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

BUREAU V. S.

OCT 26 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10396**
216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 611 Burgandy Drive			
3. NAME OF DECEASED (Type or print) Charlie Louis Baldwin				4. DATE OF DEATH Month 10-6- Day 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-05		9. AGE (In years last birthday) 51 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME Tom S. Baldwin				14. MOTHER'S MAIDEN NAME Nannie B. Toney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jesse Baldwin 5451 Burnside Circle son Sandston, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cybernetic Pneumonia 976X DUE TO Gunshot wound, head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 7-5 days 35 days </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound head, self-inflicted					
20c. TIME OF INJURY Month, Day, Year 9 Hour a. m. 9-3 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			
20f. (City or town) (County) (State) Rockville (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7 October 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/56		22c. NAME OF CEMETERY OR CREMATORY Arlington Matt.			
22d. LOCATION (City, town, or county) (State) Arlington Va							
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co 517 11th St S. E.				24a. REC'D BY REGISTRAR 10-9-56			
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, file this certificate with the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 11 1956

RECEIVED

10397

MARYLAND

STATE DEPARTMENT OF HEALTH

10434 CERTIFICATE OF DEATH

Reg. Dist. No. 216

Items 8,9 FilmG205 10-11-56 et

1015

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New York</u> COUNTY <u>Manhattan</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u>	
TOWN <u>7 weeks</u>		TOWN <u>69K-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5324 SARACOGA AVE</u>		STREET ADDRESS (If rural, give location) <u>201 West 107 St NYC</u>	
3. NAME OF DECEASED (Type or Print) <u>Della</u> (First) <u>BARBOUR</u> (Last)		4. DATE OF DEATH <u>Oct</u> (Month) <u>3</u> (Day) <u>1956</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 10/1965</u>
9. AGE last birthday <u>92</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Designer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	11. BIRTHPLACE (State or foreign country) <u>Whitney ALABAMA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Carroll Yates</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jane Lawrence</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)	
16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Lillian Olivia Bearden 5324 Saracoga Ave</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause

(a) Cerebral Vascular Accident

Antecedent cause(s)

(b) Generalized Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 20, 1950 to Oct 3, 1956, that I last saw the deceased alive on Oct 3, 1956, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles E. Hendrix M.D. 4928 St Elmo Ave Beth Md.

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>10-5-56</u>	NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	LOCATION (City, town, or county) <u>Rockville, Maryland</u>	(State)
DATE REC'D BY LOCAL REG <u>10-3-56</u>	REGISTRAR'S SIGNATURE <u>Bernard M. Thompson</u>	24. FUNERAL DIRECTOR <u>Ching Chue Funeral Home</u>	ADDRESS <u>5301 Wisconsin Ave. D.C.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

OCT 8 1956

RECEIVED

10435

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Rt #3			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR Cleveland BENSON				4. DATE OF DEATH Month Day Year October 2 1956			
5. SEX MALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/86	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 1 25		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY FIRE MAN		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William H. Benson				14. MOTHER'S MAIDEN NAME Henrietta Grimes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-26-3740			
17. INFORMANT W. Benson - Son				Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respir. failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Coronary arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 yr Indef
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal - failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1954 to 10/2, 1956 , that I last saw the deceased alive on 10/2, 1956 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 10/2/56			
PHYSICIAN'S NAME (Type) Stephen N. Jones				Rockville, Md. 10/2/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-56		22c. NAME OF CEMETERY OR CREMATORY Potomac Meth.Ch.Cem		22d. LOCATION (City, town, or county) (State) Potomac Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda Md				24a. REC'D BY REGISTRAR 10-6-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		BALTIMORE		BALTIMORE		MD		USA		OCT 10 1956		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF REPORT		PLACE OF REPORT	
HEART DISEASE		NATURAL		OCT 10 1956		BALTIMORE		BALTIMORE		MD		USA		OCT 10 1956		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		OCT 10 1956		BALTIMORE		BALTIMORE		MD		USA		OCT 10 1956		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		OCT 10 1956		BALTIMORE		BALTIMORE		MD		USA		OCT 10 1956		BALTIMORE		BALTIMORE	

BUREAU V. BUREAU

OCT 9 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

10436

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10604 Inwood Ave</u>				d. STREET ADDRESS <u>10604 Inwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Walker Lee Berry</u>				4. DATE OF DEATH <u>Oct 13 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DC Gas Lt Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Cal</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Berry</u>				14. MOTHER'S MAIDEN NAME <u>Edith Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-07-4961</u>		17. INFORMANT <u>Harriet Berry (wife)</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic tumor stage 976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shot gun wound in left upper chest</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>self-inflicted shot gun wound</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3</u> p. m. <u>10-13 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Silver Spring Montg</u> (County) <u>md</u> (State) <u>md</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>PRINCE GEORGE COUNTY, MD.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren L. Humphrey</u>				24a. REC'D BY REGISTRAR <u>10/19/56</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CONSTABLE		19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF VOTING CLERK	
21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF SHERIFF		25. SIGNATURE OF CONSTABLE	
26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF VOTING CLERK		28. SIGNATURE OF JURY		29. SIGNATURE OF JUDGE		30. SIGNATURE OF CLERK	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF CONSTABLE		33. SIGNATURE OF TOWNSHIP CLERK		34. SIGNATURE OF VOTING CLERK		35. SIGNATURE OF JURY	
36. SIGNATURE OF JUDGE		37. SIGNATURE OF CLERK		38. SIGNATURE OF SHERIFF		39. SIGNATURE OF CONSTABLE		40. SIGNATURE OF TOWNSHIP CLERK	
41. SIGNATURE OF VOTING CLERK		42. SIGNATURE OF JURY		43. SIGNATURE OF JUDGE		44. SIGNATURE OF CLERK		45. SIGNATURE OF SHERIFF	
46. SIGNATURE OF CONSTABLE		47. SIGNATURE OF TOWNSHIP CLERK		48. SIGNATURE OF VOTING CLERK		49. SIGNATURE OF JURY		50. SIGNATURE OF JUDGE	
51. SIGNATURE OF CLERK		52. SIGNATURE OF SHERIFF		53. SIGNATURE OF CONSTABLE		54. SIGNATURE OF TOWNSHIP CLERK		55. SIGNATURE OF VOTING CLERK	
56. SIGNATURE OF JURY		57. SIGNATURE OF JUDGE		58. SIGNATURE OF CLERK		59. SIGNATURE OF SHERIFF		60. SIGNATURE OF CONSTABLE	
61. SIGNATURE OF TOWNSHIP CLERK		62. SIGNATURE OF VOTING CLERK		63. SIGNATURE OF JURY		64. SIGNATURE OF JUDGE		65. SIGNATURE OF CLERK	
66. SIGNATURE OF SHERIFF		67. SIGNATURE OF CONSTABLE		68. SIGNATURE OF TOWNSHIP CLERK		69. SIGNATURE OF VOTING CLERK		70. SIGNATURE OF JURY	
71. SIGNATURE OF JUDGE		72. SIGNATURE OF CLERK		73. SIGNATURE OF SHERIFF		74. SIGNATURE OF CONSTABLE		75. SIGNATURE OF TOWNSHIP CLERK	
76. SIGNATURE OF VOTING CLERK		77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE		79. SIGNATURE OF CLERK		80. SIGNATURE OF SHERIFF	
81. SIGNATURE OF CONSTABLE		82. SIGNATURE OF TOWNSHIP CLERK		83. SIGNATURE OF VOTING CLERK		84. SIGNATURE OF JURY		85. SIGNATURE OF JUDGE	
86. SIGNATURE OF CLERK		87. SIGNATURE OF SHERIFF		88. SIGNATURE OF CONSTABLE		89. SIGNATURE OF TOWNSHIP CLERK		90. SIGNATURE OF VOTING CLERK	
91. SIGNATURE OF JURY		92. SIGNATURE OF JUDGE		93. SIGNATURE OF CLERK		94. SIGNATURE OF SHERIFF		95. SIGNATURE OF CONSTABLE	
96. SIGNATURE OF TOWNSHIP CLERK		97. SIGNATURE OF VOTING CLERK		98. SIGNATURE OF JURY		99. SIGNATURE OF JUDGE		100. SIGNATURE OF CLERK	

BUREAU V. 5

OCT 23 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10400

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eswood Lane</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring - Md</u> d. STREET ADDRESS <u>Eswood Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Alexander</u> Last <u>Bestpitch</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1958</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 16 - '81</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>insurer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. I. H.</u>				11. BIRTHPLACE (State or foreign country) <u>Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Charles Bestpitch</u>						14. MOTHER'S MAIDEN NAME <u>Mattie Pover</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Frances Bestpitch (wife)</u> Address <u>same as # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X Coronary occlusion</u> DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>10-13-58</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>OCT 16, 1958</u>				22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH'N CEM</u>				22d. LOCATION (City, town, or county) <u>Riggs Rd</u> (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Potter</u>						ADDRESS <u>254 Carroll St. N.W.</u>						24a. REC'D BY REGISTRAR <u>161958</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF DEATH _____	
PLACE OF DEATH _____		TIME OF DEATH _____	
OCCASION OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PREVIOUS ILLNESSES _____	
TREATMENT _____		MEDICATIONS _____	
PHYSICIAN'S NAME _____		SIGNATURE OF PHYSICIAN _____	
MEDICAL EXAMINER'S NAME _____		SIGNATURE OF MEDICAL EXAMINER _____	
PLACE OF INTERMENT _____		TIME OF INTERMENT _____	
NAME OF FUNERAL HOME _____		ADDRESS OF FUNERAL HOME _____	

BUREAU V. 1

OCT 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10438 CERTIFICATE OF DEATH

10401

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>CUMBERLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARLISLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 OXFORD ST. CHEVY CHASE, MD.</u>		d. STREET ADDRESS <u>256 SOUTH WEST ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCY KATHLEEN BILLMAN</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 2 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1877</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL RICE</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS. RUTH LEWIS 202 OXFORD ST. CHEVY CHASE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS.</u> <u>OVER 8 YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>56</u> , to <u>OCTOBER 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCTOBER 1</u> , 19 <u>56</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9600 OLD GEORGETOWN ROAD</u> DATE SIGNED <u>OCT. 2, 1956</u>			
ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D.		FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH D. CONNOR, M.D.</u> <u>Bethesda 14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Tr.</u>		22b. DATE THEREOF <u>10-5-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Perry Co. Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>10-2-56</u> 24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10439 CERTIFICATE OF DEATH

10402

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 115 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 208 Washington Avenue			
3. NAME OF DECEASED (Type or print) First Agnes Middle Ann Last Blakslee				4. DATE OF DEATH Month October Day 29 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1931	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter D. Hadley				14. MOTHER'S MAIDEN NAME Agnes Newnan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-20-8920		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukocytopenia (c) Acute Myelogenous Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericarditis							INTERVAL BETWEEN ONSET AND DEATH 1 week 4 months ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 6, 1956 to October 29, 1956 , that I last saw the deceased alive on October 29, 1956 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur J. Garceau M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial	Nov. 2, 1956	GALENA CEM.		GALENA, KENT CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Bellows, Millington, Md.				24a. REC'D BY REGISTRAR NOV 5 1956		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

10404

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tallons Park</i>				c. LENGTH OF STAY IN 1b <i>3 1/2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hosp</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>			
				d. STREET ADDRESS <i>RT #1</i>			
3. NAME OF DECEASED (Type or print) <i>Vennie</i>				4. DATE OF DEATH Month <i>10</i> Day <i>12</i> Year <i>1956</i>			
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>Cauc</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-27-1876</i>	
				9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <i>Tenn</i>			
13. FATHER'S NAME <i>Nathaniel Pearson</i>				14. MOTHER'S MAIDEN NAME <i>Matilda Jolly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.			
				17. INFORMANT <i>Hosp Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emaciation</i> <i>526X</i> DUE TO (b) <i>and Terminal Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Chronic Bronchiectasis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>few hours</i> <i>6 yrs. +</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>10/8/</i> 19 <i>56</i> to <i>10/12/</i> 19 <i>56</i> that I last saw the deceased alive on <i>10/11/</i> 19 <i>56</i> , and that death occurred at <i>7:55 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas H. Wolohon</i>				ADDRESS (Street, city or town, state) <i>500 Underwood St. NW</i>			
DATE SIGNED <i>10/12/56</i>							
PHYSICIAN'S NAME (Type) <i>Chas H. Wolohon</i>				Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/15/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Geo. Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>				ADDRESS <i>300 4th St NE</i>		24a. REC'D BY REGISTRAR <i>10/17/56</i>	
						24b. REGISTRAR'S SIGNATURE <i>J. H. H. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Back of Form

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL CLASS [Faint text]		12. RACE [Faint text]		13. ETHNIC ORIGIN [Faint text]		14. NATURALIZATION [Faint text]		15. CITIZENSHIP [Faint text]		16. RESIDENCE [Faint text]		17. DECEASED'S ADDRESS [Faint text]		18. DECEASED'S PHONE [Faint text]		19. DECEASED'S MAILING ADDRESS [Faint text]		20. DECEASED'S MAILING PHONE [Faint text]		21. DECEASED'S MAILING CITY [Faint text]		22. DECEASED'S MAILING STATE [Faint text]		23. DECEASED'S MAILING ZIP [Faint text]		24. DECEASED'S MAILING COUNTRY [Faint text]		25. DECEASED'S MAILING CONTINENT [Faint text]		26. DECEASED'S MAILING OCEAN [Faint text]		27. DECEASED'S MAILING ISLAND [Faint text]		28. DECEASED'S MAILING MOUNTAIN [Faint text]		29. DECEASED'S MAILING PLAIN [Faint text]		30. DECEASED'S MAILING DESERT [Faint text]		31. DECEASED'S MAILING TOWN [Faint text]		32. DECEASED'S MAILING VILLAGE [Faint text]		33. DECEASED'S MAILING HAMLET [Faint text]		34. DECEASED'S MAILING COTTAGE [Faint text]		35. DECEASED'S MAILING HOUSE [Faint text]		36. DECEASED'S MAILING FARM [Faint text]		37. DECEASED'S MAILING RANCH [Faint text]		38. DECEASED'S MAILING ESTATE [Faint text]		39. DECEASED'S MAILING LAND [Faint text]		40. DECEASED'S MAILING WATER [Faint text]		41. DECEASED'S MAILING AIR [Faint text]		42. DECEASED'S MAILING SPACE [Faint text]		43. DECEASED'S MAILING TIME [Faint text]		44. DECEASED'S MAILING LIGHT [Faint text]		45. DECEASED'S MAILING DARK [Faint text]		46. DECEASED'S MAILING SOUND [Faint text]		47. DECEASED'S MAILING SILENCE [Faint text]		48. DECEASED'S MAILING TASTE [Faint text]		49. DECEASED'S MAILING SMELL [Faint text]		50. DECEASED'S MAILING TOUCH [Faint text]		51. DECEASED'S MAILING FEEL [Faint text]		52. DECEASED'S MAILING THINK [Faint text]		53. DECEASED'S MAILING KNOW [Faint text]		54. DECEASED'S MAILING LOVE [Faint text]		55. DECEASED'S MAILING HATE [Faint text]		56. DECEASED'S MAILING CARE [Faint text]		57. DECEASED'S MAILING CONFESSION [Faint text]		58. DECEASED'S MAILING REPROOF [Faint text]		59. DECEASED'S MAILING PRAISE [Faint text]		60. DECEASED'S MAILING BLAME [Faint text]		61. DECEASED'S MAILING GUILT [Faint text]		62. DECEASED'S MAILING INNOCENCE [Faint text]		63. DECEASED'S MAILING VIRTUE [Faint text]		64. DECEASED'S MAILING VICE [Faint text]		65. DECEASED'S MAILING GOOD [Faint text]		66. DECEASED'S MAILING EVIL [Faint text]		67. DECEASED'S MAILING RIGHT [Faint text]		68. DECEASED'S MAILING WRONG [Faint text]		69. DECEASED'S MAILING JUST [Faint text]		70. DECEASED'S MAILING UNJUST [Faint text]		71. DECEASED'S MAILING FAIR [Faint text]		72. DECEASED'S MAILING UNFAIR [Faint text]		73. DECEASED'S MAILING CLEAN [Faint text]		74. DECEASED'S MAILING DIRTY [Faint text]		75. DECEASED'S MAILING PURE [Faint text]		76. DECEASED'S MAILING IMPURE [Faint text]		77. DECEASED'S MAILING HOLY [Faint text]		78. DECEASED'S MAILING UNHOLY [Faint text]		79. DECEASED'S MAILING BLESSED [Faint text]		80. DECEASED'S MAILING CURSED [Faint text]		81. DECEASED'S MAILING SAVED [Faint text]		82. DECEASED'S MAILING LOST [Faint text]		83. DECEASED'S MAILING FOUND [Faint text]		84. DECEASED'S MAILING LOST [Faint text]		85. DECEASED'S MAILING FOUND [Faint text]		86. DECEASED'S MAILING LOST [Faint text]		87. DECEASED'S MAILING FOUND [Faint text]		88. DECEASED'S MAILING LOST [Faint text]		89. DECEASED'S MAILING FOUND [Faint text]		90. DECEASED'S MAILING LOST [Faint text]		91. DECEASED'S MAILING FOUND [Faint text]		92. DECEASED'S MAILING LOST [Faint text]		93. DECEASED'S MAILING FOUND [Faint text]		94. DECEASED'S MAILING LOST [Faint text]		95. DECEASED'S MAILING FOUND [Faint text]		96. DECEASED'S MAILING LOST [Faint text]		97. DECEASED'S MAILING FOUND [Faint text]		98. DECEASED'S MAILING LOST [Faint text]		99. DECEASED'S MAILING FOUND [Faint text]		100. DECEASED'S MAILING LOST [Faint text]	
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BUREAU V. 2

OCT 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10440
CERTIFICATE OF DEATH

10404
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. Of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Norbeck, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena's Rest Home				d. STREET ADDRESS 1604 - Buchanan Street N.W.			
3. NAME OF DECEASED (Type or print) First FRANK Middle BORZI Last				4. DATE OF DEATH Month October Day 27 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 6 Days 2 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor - Shoe Store....		10b. KIND OF BUSINESS OR INDUSTRY ITALY	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Carmelo Borzi				14. MOTHER'S MAIDEN NAME Agata Navarria			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. A. Borzi (Wife), 1604 Buchanan St. N.W. - D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, cerebral 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 mos 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 10 , 19 56 to Oct 27 , 19 56 , that I last saw the deceased alive on Oct 27 , 19 56 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A.W. Smith M.D. 4601 16th St. NW				DATE SIGNED 10/27/56			
PHYSICIAN'S NAME (Type) A.W. SMITH				ADDRESS (Street, city or town, state) Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/30/1956		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co.				24. REGISTRY BY REGISTRAR 1300-N ST. N.W. Wash. D.C.			
25. REGISTRAR'S SIGNATURE Frances Potter							

CERTIFICATE OF DEATH

NAME OF DECEASED ST. WILLIAM'S HOSPITAL		DATE OF DEATH 10/30/1956	
PLACE OF DEATH ST. WILLIAM'S HOSPITAL		AGE 75	
SEX Male		RACE White	
DATE OF BIRTH 10/25/1881		PLACE OF BIRTH ITALY	
CITY OF BIRTH BARI		COUNTRY OF BIRTH ITALY	
MARRIAGE MARRIED		DATE OF MARRIAGE 1908	
NAME OF SPOUSE MRS. J. J. J.		DATE OF DEATH 10/30/1956	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE HEART DISEASE		MEDICAL HISTORY HEART DISEASE	
PREVIOUS ILLNESS HEART DISEASE		TREATMENT HEART DISEASE	
SIGNATURE OF PHYSICIAN J. J. J.		SIGNATURE OF DECEASED J. J. J.	
DATE OF SIGNATURE 10/30/1956		DATE OF SIGNATURE 10/30/1956	

BUREAU V. S.

OCT 31 1956

RECEIVED

10441

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - R-2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville R-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Locke Rd.</u>				d. STREET ADDRESS <u>7 - Locke Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Brown</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>I.N.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary E. Brown (wife)</u> Address <u>Dumfries #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/20/56</u>		<u>Lincoln Memorial</u>		<u>Suitland, Md</u>	
23a. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Suoroden</u>				23b. ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR	
				24b. REGISTRAR'S SIGNATURE <u>Laurell Kragtorp</u>		DATE <u>10/22/56</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ph.ec

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 23 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10442 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH 10406
 Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reckville Rt # 3</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Wrenn Carroll</u>				4. DATE OF DEATH Month Day Year <u>October 20 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/14/01</u>	
				9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis I Wrenn</u>				14. MOTHER'S MAIDEN NAME <u>Irene Graves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs</u> <u>15 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1950</u> , to <u>Oct. 1956</u> , that I last saw the deceased alive on <u>Oct. 20</u> , 1956, and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. D. Brumby</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Sprig, Md. 10/20/56</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Warner E. Pumphrey Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Kertine B. Lawler</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text.

BUREAU V. 2

OCT 23 1956

RECEIVED

Continuation of the death certificate form, including fields for medical history, autopsy, and certification. The form is partially filled with handwritten text.

10443

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3½ yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2614 URBANA DRIVE				d. STREET ADDRESS 2614 URBANA DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle LUCILLE Last CARTER				4. DATE OF DEATH Month OCTOBER Day 6 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/83	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) AUGUSTA, GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DAVIDSON				14. MOTHER'S MAIDEN NAME FLORENCE DAVIDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-12-1654B		17. INFORMANT Address Mr. Joseph L. Carter, 2614 Urbana Drive Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 150 , to Oct. 6 , 19 56 , that I last saw the deceased alive on Oct 6 , 19 56 , and that death occurred at 3:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9013 Flower Ave Silver Spring, Md. DATE SIGNED Oct. 7, 1956							
ACTUAL SIGNATURE Margaret T. Snow, M.D.							
PHYSICIAN'S NAME (Type) Margaret T. Snow, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1956		22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 10/9/56	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

CERTIFICATE OF DEATH

PLACE OF DEATH HOSPITAL		COUNTY BALTIMORE	
DATE OF DEATH OCT 15 1956		TIME OF DEATH 10:30 AM	
AGE 65		SEX M	
RACE W		EDUCATION HIGH SCHOOL	
OCCUPATION RETIRED		MARRIAGE M	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
MIDDLE CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
UNDERLYING CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
DATE OF DEATH OCT 15 1956		TIME OF DEATH 10:30 AM	
PLACE OF DEATH HOSPITAL		COUNTY BALTIMORE	
DATE OF DEATH OCT 15 1956		TIME OF DEATH 10:30 AM	
AGE 65		SEX M	
RACE W		EDUCATION HIGH SCHOOL	
OCCUPATION RETIRED		MARRIAGE M	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
MIDDLE CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
UNDERLYING CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	

BUREAU V. E.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10444
CERTIFICATE OF DEATH

10408

Reg. Dist. No. **217**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN TB 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHARON CHRONIC Hosp.				d. STREET ADDRESS 2600 17th ST N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle G Last Chapin				4. DATE OF DEATH Month OCT. Day 27 Year 1956			
5. SEX F		6. COLOR OR RACE WYHite		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 31, 1880	
				9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ont. Canada	
13. FATHER'S NAME George G. Rath				14. MOTHER'S MAIDEN NAME Heleen S. Want			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address PT's Admission Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Failure 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cystitis							INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from OCT 2 , 19 56 , to OCT 27 , 19 56 , that I last saw the deceased alive on OCT 26 , 19 56 , and that death occurred at 2 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. H. Ligon				ADDRESS (Street, city or town, state) Farmington, Md.		DATE SIGNED 10/27/56	
PHYSICIAN'S NAME (Type) E. H. Ligon							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/56		22c. NAME OF CEMETERY OR CREMATORY National Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company 2901 14th St. NW				24a. REC'D BY REGISTRAR 10-28-56		24b. REGISTRAR'S SIGNATURE Arthur B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. RACE	
7. OCCUPATION		8. CAUSE OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. NAME OF FATHER		12. NAME OF MOTHER	
13. NAME OF SPOUSE		14. NAME OF CHILDREN	
15. NAME OF NEXT OF KIN		16. NAME OF PHYSICIAN	
17. NAME OF BURIAL PLACE		18. NAME OF FUNERAL HOME	
19. NAME OF MINISTER		20. NAME OF CHURCH	
21. NAME OF CEMETERY		22. NAME OF INTERMENT	
23. NAME OF CARRIER		24. NAME OF COFFIN	
25. NAME OF CASK		26. NAME OF CASK	
27. NAME OF CASK		28. NAME OF CASK	
29. NAME OF CASK		30. NAME OF CASK	
31. NAME OF CASK		32. NAME OF CASK	
33. NAME OF CASK		34. NAME OF CASK	
35. NAME OF CASK		36. NAME OF CASK	
37. NAME OF CASK		38. NAME OF CASK	
39. NAME OF CASK		40. NAME OF CASK	
41. NAME OF CASK		42. NAME OF CASK	
43. NAME OF CASK		44. NAME OF CASK	
45. NAME OF CASK		46. NAME OF CASK	
47. NAME OF CASK		48. NAME OF CASK	
49. NAME OF CASK		50. NAME OF CASK	
51. NAME OF CASK		52. NAME OF CASK	
53. NAME OF CASK		54. NAME OF CASK	
55. NAME OF CASK		56. NAME OF CASK	
57. NAME OF CASK		58. NAME OF CASK	
59. NAME OF CASK		60. NAME OF CASK	
61. NAME OF CASK		62. NAME OF CASK	
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65. NAME OF CASK		66. NAME OF CASK	
67. NAME OF CASK		68. NAME OF CASK	
69. NAME OF CASK		70. NAME OF CASK	
71. NAME OF CASK		72. NAME OF CASK	
73. NAME OF CASK		74. NAME OF CASK	
75. NAME OF CASK		76. NAME OF CASK	
77. NAME OF CASK		78. NAME OF CASK	
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87. NAME OF CASK		88. NAME OF CASK	
89. NAME OF CASK		90. NAME OF CASK	
91. NAME OF CASK		92. NAME OF CASK	
93. NAME OF CASK		94. NAME OF CASK	
95. NAME OF CASK		96. NAME OF CASK	
97. NAME OF CASK		98. NAME OF CASK	
99. NAME OF CASK		100. NAME OF CASK	

BUREAU V. S.

NOV 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10445
CERTIFICATE OF DEATH

10409
216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>2 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hosp.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Dist. of Col.</i> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>7809 14th St. N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Jennie O'houghlin Cleary</i>			4. DATE OF DEATH Month <i>Oct.</i> Day <i>26</i> Year <i>1956</i>								
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <i>Sept. 4, 1878</i>		9. AGE (In years last birthday) <i>78</i> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Connecticut</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>Patrick O'houghlin</i>			14. MOTHER'S MAIDEN NAME <i>Harvey</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Grace Talbot - above</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i> (b) <i>Hypertension</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>?</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatic Myocarditis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town)		(County)		(State)							
21. I certify that I attended the deceased from <i>Feb</i> <i>1953</i> , to <i>Feb</i> <i>1956</i> , that I last saw the deceased alive on <i>25 Oct</i> <i>1956</i> , and that death occurred at <i>7:15 A.M.</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>William D. And</i> M.D.			ADDRESS (Street, city or town, state) <i>9006 Glenville Rd</i>								
PHYSICIAN'S NAME (Type) <i>William D. And</i>			DATE SIGNED <i>10/26/56</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>OCT. 30/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ST. JAMES</i>							
22d. LOCATION (City, town, or county) <i>NAUGATUCK</i>		(State) <i>CONN.</i>									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>			ADDRESS <i>3821-14th St. N.W. Wash. D.C.</i>								
24a. REC'D BY REGISTRAR <i>10-29-56</i>		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10410

10446

Item 8 FilmG205 10-25-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles William Middle Kendrick Last Cohen				4. DATE OF DEATH 10 Month 12 Day 59 Year			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/1877 1870	9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carlonia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Willis Cohen			
14. MOTHER'S MAIDEN NAME Sarah Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 22 407 9607				17. INFORMANT Mrs Lillie Cohen Address 3911 Hampden St. Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis Chronic 442X DUE TO Hypertensive Cardiorenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 28, 1956 to Oct. 12, 1956 , that I last saw the deceased alive on Oct. 11, 1956 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell M.D.				DATE SIGNED 10-15-56			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.				ADDRESS (Street, city or town, state) Norbeck Rd. 1			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Summerville				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 10-16-56	
24b. REGISTRAR'S SIGNATURE Gertrude B. Langer							

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		35	
Date of Birth		1920	
Place of Birth		Maryland	
Usual Residence		123 Main St, Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		Oct 20, 1956	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

OCT 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10411

10405

CERTIFICATE OF DEATH

Reg. Dist. No.

723

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>R</u> Last <u>Corcoran</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>15th</u> Year <u>1956</u>	
5. SEX <u>Fe</u>	6. COLOR OF RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 - 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Rutty</u>		14. MOTHER'S MAIDEN NAME <u>Anna Griswold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1301 Ridge place</u>	
17. INFORMANT <u>Melba H. Corcoran</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized, with cerebral anoxia</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)		21. I certify that I attended the deceased from <u>July 1, 1956</u> to <u>October 15, 1956</u> that I last saw the deceased alive on <u>October 15, 1956</u> and that death occurred at <u>8:47 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>J. M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7201 Carroll Ave. Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Oct 18 '56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Washington</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros. 1661 7th Hope Rd S.E.</u>		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Roddy</u>	
DATE <u>OCT 18 1956</u>			

CERTIFICATE OF DEATH

11-20-56

NAME OF DECEASED: *John R. Conner*

DATE OF DEATH: *11-18-56*

PLACE OF DEATH: *Home*

AGE: *68*

SEX: *M*

RACE: *W*

EDUCATION: *High School*

OCCUPATION: *Retired*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

DATE OF BIRTH: *11-18-1888*

PLACE OF BIRTH: *Washington, D.C.*

DATE OF DEATH: *11-18-56*

PLACE OF DEATH: *Home*

AGE: *68*

SEX: *M*

RACE: *W*

EDUCATION: *High School*

OCCUPATION: *Retired*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

BUREAU V. 3

OCT 18 1956

RECEIVED

11-20-56

NAME OF DECEASED: *John R. Conner*

DATE OF DEATH: *11-18-56*

PLACE OF DEATH: *Home*

AGE: *68*

SEX: *M*

RACE: *W*

EDUCATION: *High School*

OCCUPATION: *Retired*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

DATE OF BIRTH: *11-18-1888*

PLACE OF BIRTH: *Washington, D.C.*

DATE OF DEATH: *11-18-56*

PLACE OF DEATH: *Home*

AGE: *68*

SEX: *M*

RACE: *W*

EDUCATION: *High School*

OCCUPATION: *Retired*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

1. PLACE OF DEATH a. COUNTY <u>MONT COMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>CAMDEN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLOUCESTER</u> 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>815 MONMOUTH ST</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>B</u> Last <u>COSTELLO</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 26 1901</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>15</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>	
11. BIRTHPLACE (State or foreign country) <u>CAMDEN, NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN J BURKE</u>		14. MOTHER'S MAIDEN NAME <u>O CONNOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>THOMAS A INGLESBY</u>		Address <u>CHEVY CHASE, MD 4609 WILLARD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153X</u> DUE TO <u>Carcinoma Bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>11 mo.</u> (c) <u>11 mo.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INANITION CACHEXIA, BLOCKAGE OF URETERS due to (a)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1</u> , 19 <u>56</u> , to <u>Oct. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ELBERT T. PHELPS</u> M.D.		ADDRESS (Street, city or town, state) <u>5009 SCARSDALE RD</u>	
PHYSICIAN'S NAME (Type) <u>ELBERT T PHELPS</u>		DATE SIGNED <u>WASH. 16 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW ST MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>Bellman N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Heine</u>		ADDRESS <u>300-4 E. ST N.E. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 10-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
OCT 22 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10413

Reg. Dist. No. 216

10448

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7918 Sleaford Road Home				d. STREET ADDRESS 7918 Sleaford Road Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) EARL A. COX				4. DATE OF DEATH October 7, 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1888	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 9 Days 15		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Fireman				10b. KIND OF BUSINESS OR INDUSTRY Fire Fighter		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME James L. Cox				14. MOTHER'S MAIDEN NAME G. M. Scaggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Julia Cox- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 10-8-56		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 10 1956
BUREAU V. E.

NAME OF DECEASED: James I. Cox
 SEX: Male AGE: 32 DATE OF BIRTH: Dec. 23, 1924
 RACE: White COLOR OF HAIR: Light Brown COLOR OF EYES: Blue
 OCCUPATION: None PLACE OF BIRTH: Washington, D.C.
 MARITAL STATUS: Single PRESENT ADDRESS: 11111 Cox - Room 2
 DATE OF DEATH: October 1, 1956 TIME OF DEATH: 7:10
 PLACE OF DEATH: 710 Leonard Avenue - Boston
 CAUSE OF DEATH: Coronary Thrombosis
 MANNER OF DEATH: None
 SIGNATURE OF EXAMINER: [Signature]
 OFFICIAL SEAL: [Seal]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

10449

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10414

215.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. LENGTH OF STAY IN 1b 5 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.	
d. STREET ADDRESS 1217 Allison Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Timothy Middle James Last DARRAGH		4. DATE OF DEATH Month October Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James J. DARRAGH		14. MOTHER'S MAIDEN NAME Marilyn E. WAHLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) James J. DARRAGH		Address (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure to establish respiration 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c) Immaturity		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Oct. 19 56 , to 2 Oct. 19 56 , that I last saw the deceased alive on 2 Oct. 19 56 , and that death occurred at 2:57 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Mazur		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
DATE SIGNED 10-3-56			
PHYSICIAN'S NAME (Type) John H. Mazur, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphery		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 10-2-56		24b. REGISTRAR'S SIGNATURE Mary E. Cassell	

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10450

CERTIFICATE OF DEATH

10415

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHEVY CHASE		LENGTH OF STAY (in this place) 26 Yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CHEVY CHASE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5608 WESTERN AVENUE				STREET ADDRESS (If rural give location) 5608 WESTERN AVENUE			
3. NAME OF DECEASED (First) ANNA (Middle) MARY (Last) DASHIELL				4. DATE OF DEATH (Month) 10 (Day) 26 (Year) 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 5/24/1868		9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACKSON D. STONEROAD				14. MOTHER'S MAIDEN NAME JANE A. McKEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS DOROTHY D. ACORN 5608 WESTERN AVENUE, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) myo cardiac failure				INTERVAL BETWEEN ONSET AND DEATH 6+ wks.			
ANTECEDENT CAUSE(S) DUE TO (B) arterio-sclerotic heart disease				2+ yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Hemorrhagic cystitis				4+ wks.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 15, 1952 to Oct 26, 1956, that I last saw the deceased alive on Oct 26, 1956, and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
SIGNATURE C. H. Rickwine M.D.				ADDRESS (Street, city, town, state) 5522 Western Ave. Washington, D.C. DATE SIGNED Oct 26, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/29/56		NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		LOCATION (City, town, or county) Washington, D.C. (State)	
24. REC'D BY REGISTRAR DATE 10-29-56		REGISTRAR'S SIGNATURE L. Essie M. Thompson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S. H. Hines Company-2901 14th St Washington, D.C.			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
2000 WEST 100th STREET		LABORER		HEART DISEASE		NATURAL		OCT 21 1956		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
OCT 21 1956		BALTIMORE, MD.		OCT 21 1956		BALTIMORE, MD.		OCT 21 1956		BALTIMORE, MD.	

James H. Harris
2000 West 100th Street

James H. Harris

BUREAU V. 2

OCT 31 1956

RECEIVED

2258
2258
2258

2258
2258
2258

SMITHSONIAN INSTITUTION

RECEIVED
 OCT 21 1956
 BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10451 CERTIFICATE OF DEATH

10416

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		d. STREET ADDRESS 3000 MCCOMAS AVENUE	
3. NAME OF DECEASED (Type or print) First ELSA MYRTLE Middle DAVIS Last		4. DATE OF DEATH OCTOBER 9 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1868
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CLARKSBURG, INDIANA
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME UNKNOWN MARSHALL	
14. MOTHER'S MAIDEN NAME HARRIETT BOWLING		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address (MD.) MRS. FRANKLIN B. MADES, 3518 NIMITZ RD., KENSINGTON,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 153X DUE TO Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of colon (c) 1 yr + 2 yr +			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 19, 54 to Sept 18, 1956 , that I last saw the deceased alive on 9/18 19 56 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James Coleman MD M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 113 Carroll St NW Washington 10/4/56 DC	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 13, 1956	22c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON MEMORIAL	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Edenox E. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR 10/9/56
		24b. REGISTRAR'S SIGNATURE Frances Foster	

Medical examiner notified (Frank B. Brochart) + approved
 me to sign certificate James Coleman MD

10452

CERTIFICATE OF DEATH

10417

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pootersville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pootersville - Rural - 1x</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hughes Road</i>				d. STREET ADDRESS <i>Hughes Road</i>			
3. NAME OF DECEASED (Type or print) <i>Davis, Lawrence Preston</i>				4. DATE OF DEATH <i>Oct - 15 - 1936</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb - 28 - 1912</i>		9. AGE (In years lost birthday) <i>44</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farming</i>		11. BIRTHPLACE (State or foreign country) <i>Pootersville, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		
13. FATHER'S NAME <i>Jess Holland</i>				14. MOTHER'S MAIDEN NAME <i>Rosie Lee Davis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-18-8252</i>		17. INFORMANT <i>Charles Louis Bramson, Pootersville, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute heart failure (acute dilatation)</i> 443X DUE TO <i>High Arterial Tension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>?</i> DUE TO (c) <i>?</i>							INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct - 15 - 1936</i> , to <i>Oct - 15 - 1936</i> , that I last saw the deceased alive on <i>Oct - 15 - 1936</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William C. Miller</i>			ADDRESS (Street, city or town, state) <i>7 - Brooke Ave., Gaithersburg, Md.</i>				
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER, M.D.</i>			DATE SIGNED <i>G. A. ITHERSBURG, MD</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/18/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Elijah</i>		22d. LOCATION (City, town, or county) (State) <i>Pootersville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swunders</i>				ADDRESS <i>Rockville, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Charles W. Elgin</i>	
				24a. REC'D BY REGISTRAR <i>10/19/56</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *Robert K. Swanton - (phonetic)*

2. SEX: *Male*

3. AGE: *61*

4. DATE OF BIRTH: *10/18/1915*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *None*

7. CAUSE OF DEATH: *Heart Disease*

8. PLACE OF DEATH: *Home*

9. DATE OF DEATH: *10/22/1956*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. S.

OCT 22 1956

RECEIVED

Robert K. Swanton - (phonetic)
10/22/1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10418

10453

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3915 Underwood Street</u>				d. STREET ADDRESS <u>3915 Underwood Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>AUSTIN</u> First <u>P. DeWILDE, Sr.</u> Middle Last				4. DATE OF DEATH <u>October 11,</u> 19 <u>56</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1906</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brokerage</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Us</u>	
13. FATHER'S NAME <u>George C. DeWilde</u>				14. MOTHER'S MAIDEN NAME <u>Marion Hutchison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Louise R. DeWilde - Item # 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>153X</u> IMMEDIATE CAUSE (a) <u>Carcinoma, colon (sigmoid) with generalized carcinomatosis, abdominal</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs. 3.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>max.</u> 19 <u>55</u> , to <u>Oct. 11,</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 10,</u> 19 <u>56</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip H. Varner,</u> M.D. <u>7702 Conn. Ave.,</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>10/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Philip H. Varner</u>				<u>Chevy Chase, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
AT HOME		MARRIED	
HOSPITAL		SINGLE	
NURSING HOME		DIVORCED	
OTHER		WIDOWED	
DATE OF DEATH		DATE OF MARRIAGE	
OCT 18 1956		OCT 18 1956	
TIME OF DEATH		TIME OF MARRIAGE	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF BIRTH	
OCT 18 1956		OCT 18 1956	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH	
AT HOME		AT HOME	
HOSPITAL		HOSPITAL	
NURSING HOME		NURSING HOME	
OTHER		OTHER	
DATE OF DEATH		DATE OF DEATH	
OCT 18 1956		OCT 18 1956	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		DATE OF BIRTH	
OCT 18 1956		OCT 18 1956	
TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM	

BUREAU V. S.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454

CERTIFICATE OF DEATH

10419

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 6 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3112 EDGEWOOD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSA Middle CATHERINE Last DIXON				4. DATE OF DEATH Month OCTOBER Day 18 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/84	
9. AGE (In years most birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical				10b. KIND OF BUSINESS OR INDUSTRY Southern Railway Woodward & Lothrop		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE KNORLEINE				14. MOTHER'S MAIDEN NAME MARY WINDHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-20-2363		17. INFORMANT Address Mr. Laurence E. Dixon, 3112 Edgewood Road Kensington, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Heart Failure DUE TO (c) Hypertensive Heart Disease INTERVAL BETWEEN ONSET AND DEATH 1 hr 30 Years Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-19 , 19 54 , to 10-18 , 19 56 , that I last saw the deceased alive on 10-18 , 19 56 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11602 Georgia Ave. Silver Spring, Maryland DATE SIGNED 10-18-56							
ACTUAL SIGNATURE Morris Perry				PHYSICIAN'S NAME (Type) Morris Perry M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert B. Rumphrey				24a. REC'D BY REGISTRAR DATE 10/23/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JOHNSON		AGE 45		SEX M		RACE W		DATE OF BIRTH 11-15-1910		PLACE OF BIRTH BALTIMORE, MD.	
DATE OF DEATH 11-25-1956		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 11-25-1956	
DECEASED'S RESIDENCE 1234 E. BALTIMORE ST. BALTIMORE, MD.		DECEASED'S OCCUPATION CLERK		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL		DECEASED'S SERVICE ARMY	
DECEASED'S SIGNATURE JOHN J. JOHNSON		DECEASED'S ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MD.		DECEASED'S PHONE NO. 123-4567		DECEASED'S SOCIAL SECURITY NO. 123-45-6789		DECEASED'S MOTHER'S MARRIAGE NO. 1234		DECEASED'S MOTHER'S BIRTH DATE 11-15-1910	
DECEASED'S FATHER'S NAME JOHN J. JOHNSON		DECEASED'S FATHER'S BIRTH DATE 11-15-1910		DECEASED'S FATHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S FATHER'S OCCUPATION CLERK		DECEASED'S FATHER'S MARITAL STATUS MARRIED		DECEASED'S FATHER'S RELIGION METHODIST	
DECEASED'S MOTHER'S NAME JOHN J. JOHNSON		DECEASED'S MOTHER'S BIRTH DATE 11-15-1910		DECEASED'S MOTHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S MOTHER'S OCCUPATION CLERK		DECEASED'S MOTHER'S MARITAL STATUS MARRIED		DECEASED'S MOTHER'S RELIGION METHODIST	
DECEASED'S SISTER'S NAME JOHN J. JOHNSON		DECEASED'S SISTER'S BIRTH DATE 11-15-1910		DECEASED'S SISTER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S SISTER'S OCCUPATION CLERK		DECEASED'S SISTER'S MARITAL STATUS MARRIED		DECEASED'S SISTER'S RELIGION METHODIST	
DECEASED'S BROTHER'S NAME JOHN J. JOHNSON		DECEASED'S BROTHER'S BIRTH DATE 11-15-1910		DECEASED'S BROTHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S BROTHER'S OCCUPATION CLERK		DECEASED'S BROTHER'S MARITAL STATUS MARRIED		DECEASED'S BROTHER'S RELIGION METHODIST	
DECEASED'S SIGNATURE JOHN J. JOHNSON		DECEASED'S ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MD.		DECEASED'S PHONE NO. 123-4567		DECEASED'S SOCIAL SECURITY NO. 123-45-6789		DECEASED'S MOTHER'S MARRIAGE NO. 1234		DECEASED'S MOTHER'S BIRTH DATE 11-15-1910	
DECEASED'S FATHER'S NAME JOHN J. JOHNSON		DECEASED'S FATHER'S BIRTH DATE 11-15-1910		DECEASED'S FATHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S FATHER'S OCCUPATION CLERK		DECEASED'S FATHER'S MARITAL STATUS MARRIED		DECEASED'S FATHER'S RELIGION METHODIST	
DECEASED'S MOTHER'S NAME JOHN J. JOHNSON		DECEASED'S MOTHER'S BIRTH DATE 11-15-1910		DECEASED'S MOTHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S MOTHER'S OCCUPATION CLERK		DECEASED'S MOTHER'S MARITAL STATUS MARRIED		DECEASED'S MOTHER'S RELIGION METHODIST	
DECEASED'S SISTER'S NAME JOHN J. JOHNSON		DECEASED'S SISTER'S BIRTH DATE 11-15-1910		DECEASED'S SISTER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S SISTER'S OCCUPATION CLERK		DECEASED'S SISTER'S MARITAL STATUS MARRIED		DECEASED'S SISTER'S RELIGION METHODIST	
DECEASED'S BROTHER'S NAME JOHN J. JOHNSON		DECEASED'S BROTHER'S BIRTH DATE 11-15-1910		DECEASED'S BROTHER'S PLACE OF BIRTH BALTIMORE, MD.		DECEASED'S BROTHER'S OCCUPATION CLERK		DECEASED'S BROTHER'S MARITAL STATUS MARRIED		DECEASED'S BROTHER'S RELIGION METHODIST	

BUREAU V. 51

NOV 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420

10455

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>		c. LENGTH OF STAY IN 1b <u>16 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>6825 Red Top Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margarat</u> Middle <u>Petty</u> Last <u>Dodge</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Anacostia D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry S. Petty</u>				14. MOTHER'S MAIDEN NAME <u>Margar et Hodges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harry P. Dodge</u> Address <u>Olney md</u> <u>Batchelor Forest</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy thrombotic</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiac vascular disease</u> DUE TO (c) <u>Diabetic mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs</u> <u>11 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>52</u> , to <u>Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>56</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. D. Bonifant</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>10/23/56</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>10-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
								</															

10406

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANATORIUM & HOSPITAL</u>				d. STREET ADDRESS <u>3612 LITLEDALE RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE ELIZABETH ELLIN</u>				4. DATE OF DEATH Month Day Year <u>10 26 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/79</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN EDWARD MORAN</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN WYSAIT LOVELESS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>JOHN HENRY PARATER SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA AND CEREBROVASCULAR ACCIDENT</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u> DUE TO (c) <u>LONG STANDING</u>							INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO INJURY</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>10/26 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 35</u> , to <u>10/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>56</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Henry W. Stout</u> M.D.				ADDRESS <u>10011 Georgia Ave Silver Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold G. Haffner</u> ADDRESS <u>8431 Georgia Ave Spring</u>				24a. REC'D BY REGISTRAR <u>John R. Dault</u>		24b. REGISTRAR'S SIGNATURE <u>John R. Dault</u>	
DATE <u>10/19/56</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 18 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Maryland</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	

BUREAU V. S.

OCT 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10422
Reg. Dist. No.

10427

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Rockville</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Monroe St</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>EDWARD</i> Middle <i>J</i> Last <i>FARRELLY</i>				4. DATE OF DEATH Month <i>10</i> Day <i>25</i> Year <i>1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 18, 1895</i>	
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>7</i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Thomas F. Farrelly</i>				14. MOTHER'S MAIDEN NAME <i>Mathilda Hermann</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <i>WWI</i>				16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Wife</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemopericardium</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ruptured myocardial infarct, post mortem</i> DUE TO <i>2 days</i> (c) <i>Thrombosis distal right coronary</i> <i>2 days</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i></i>				20g. (County) <i></i>		20h. (State) <i></i>	
21. I certify that I attended the deceased from <i>June, 1946</i> to <i>Oct 23, 1956</i> , that I last saw the deceased alive on <i>Oct 23, 1956</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. D. Daughton</i>				ADDRESS (Street, city or town, state) <i>917 20th St NW WASHINGTON 6 DC</i>			
PHYSICIAN'S NAME (Type) <i>A. D. DAUGHTON</i>				DATE SIGNED <i>10/25/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-tr.</i>		22b. DATE THEREOF <i>10-25-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Mercer Pa</i>	
23. BURIAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				ADDRESS <i>Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>10/26/56</i>	
				24b. REGISTRAR'S SIGNATURE <i>Laurel Kragtorp</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Oct 25 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF WITNESSES <i>John A. Smith</i>	
19. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		20. SIGNATURE OF CLERK <i>John A. Smith</i>		21. SIGNATURE OF JURY <i>John A. Smith</i>	
22. SIGNATURE OF JURY <i>John A. Smith</i>		23. SIGNATURE OF JURY <i>John A. Smith</i>		24. SIGNATURE OF JURY <i>John A. Smith</i>	
25. SIGNATURE OF JURY <i>John A. Smith</i>		26. SIGNATURE OF JURY <i>John A. Smith</i>		27. SIGNATURE OF JURY <i>John A. Smith</i>	
28. SIGNATURE OF JURY <i>John A. Smith</i>		29. SIGNATURE OF JURY <i>John A. Smith</i>		30. SIGNATURE OF JURY <i>John A. Smith</i>	
31. SIGNATURE OF JURY <i>John A. Smith</i>		32. SIGNATURE OF JURY <i>John A. Smith</i>		33. SIGNATURE OF JURY <i>John A. Smith</i>	
34. SIGNATURE OF JURY <i>John A. Smith</i>		35. SIGNATURE OF JURY <i>John A. Smith</i>		36. SIGNATURE OF JURY <i>John A. Smith</i>	
37. SIGNATURE OF JURY <i>John A. Smith</i>		38. SIGNATURE OF JURY <i>John A. Smith</i>		39. SIGNATURE OF JURY <i>John A. Smith</i>	
40. SIGNATURE OF JURY <i>John A. Smith</i>		41. SIGNATURE OF JURY <i>John A. Smith</i>		42. SIGNATURE OF JURY <i>John A. Smith</i>	
43. SIGNATURE OF JURY <i>John A. Smith</i>		44. SIGNATURE OF JURY <i>John A. Smith</i>		45. SIGNATURE OF JURY <i>John A. Smith</i>	
46. SIGNATURE OF JURY <i>John A. Smith</i>		47. SIGNATURE OF JURY <i>John A. Smith</i>		48. SIGNATURE OF JURY <i>John A. Smith</i>	
49. SIGNATURE OF JURY <i>John A. Smith</i>		50. SIGNATURE OF JURY <i>John A. Smith</i>		51. SIGNATURE OF JURY <i>John A. Smith</i>	
52. SIGNATURE OF JURY <i>John A. Smith</i>		53. SIGNATURE OF JURY <i>John A. Smith</i>		54. SIGNATURE OF JURY <i>John A. Smith</i>	
55. SIGNATURE OF JURY <i>John A. Smith</i>		56. SIGNATURE OF JURY <i>John A. Smith</i>		57. SIGNATURE OF JURY <i>John A. Smith</i>	
58. SIGNATURE OF JURY <i>John A. Smith</i>		59. SIGNATURE OF JURY <i>John A. Smith</i>		60. SIGNATURE OF JURY <i>John A. Smith</i>	
61. SIGNATURE OF JURY <i>John A. Smith</i>		62. SIGNATURE OF JURY <i>John A. Smith</i>		63. SIGNATURE OF JURY <i>John A. Smith</i>	
64. SIGNATURE OF JURY <i>John A. Smith</i>		65. SIGNATURE OF JURY <i>John A. Smith</i>		66. SIGNATURE OF JURY <i>John A. Smith</i>	
67. SIGNATURE OF JURY <i>John A. Smith</i>		68. SIGNATURE OF JURY <i>John A. Smith</i>		69. SIGNATURE OF JURY <i>John A. Smith</i>	
70. SIGNATURE OF JURY <i>John A. Smith</i>		71. SIGNATURE OF JURY <i>John A. Smith</i>		72. SIGNATURE OF JURY <i>John A. Smith</i>	
73. SIGNATURE OF JURY <i>John A. Smith</i>		74. SIGNATURE OF JURY <i>John A. Smith</i>		75. SIGNATURE OF JURY <i>John A. Smith</i>	
76. SIGNATURE OF JURY <i>John A. Smith</i>		77. SIGNATURE OF JURY <i>John A. Smith</i>		78. SIGNATURE OF JURY <i>John A. Smith</i>	
79. SIGNATURE OF JURY <i>John A. Smith</i>		80. SIGNATURE OF JURY <i>John A. Smith</i>		81. SIGNATURE OF JURY <i>John A. Smith</i>	
82. SIGNATURE OF JURY <i>John A. Smith</i>		83. SIGNATURE OF JURY <i>John A. Smith</i>		84. SIGNATURE OF JURY <i>John A. Smith</i>	
85. SIGNATURE OF JURY <i>John A. Smith</i>		86. SIGNATURE OF JURY <i>John A. Smith</i>		87. SIGNATURE OF JURY <i>John A. Smith</i>	
88. SIGNATURE OF JURY <i>John A. Smith</i>		89. SIGNATURE OF JURY <i>John A. Smith</i>		90. SIGNATURE OF JURY <i>John A. Smith</i>	
91. SIGNATURE OF JURY <i>John A. Smith</i>		92. SIGNATURE OF JURY <i>John A. Smith</i>		93. SIGNATURE OF JURY <i>John A. Smith</i>	
94. SIGNATURE OF JURY <i>John A. Smith</i>		95. SIGNATURE OF JURY <i>John A. Smith</i>		96. SIGNATURE OF JURY <i>John A. Smith</i>	
97. SIGNATURE OF JURY <i>John A. Smith</i>		98. SIGNATURE OF JURY <i>John A. Smith</i>		99. SIGNATURE OF JURY <i>John A. Smith</i>	
100. SIGNATURE OF JURY <i>John A. Smith</i>		101. SIGNATURE OF JURY <i>John A. Smith</i>		102. SIGNATURE OF JURY <i>John A. Smith</i>	

BUREAU V. S.

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 8,9 FilmG205 10-15-56 et
CERTIFICATE OF DEATH

10423

Reg. Dist. No.

223

10407

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>1001 Merrimack Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>(None)</u> Middle <u>Fleetell</u> Last				4. DATE OF DEATH <u>Oct. 1</u> Month <u>1</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-77</u>	9. AGE (In years last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Portnow</u>			14. MOTHER'S MAIDEN NAME <u>Bessie (unknown)</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mary C. Clarke R.N.</u> Address <u>Silver Spring, Md. 9107 Flower Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> <u>420.0</u> DUE TO <u>Arrhythmia fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 weeks</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-23</u> , 19 <u>56</u> , to <u>10-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>56</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Manchester</u> M.D.				ADDRESS (Street, city or town, state) <u>3200-16 St NW. DC</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN MANCHESTER</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>20th '56 NATL. MEM. PARK</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>FALLS CHURCH. VA</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				24a. REC'D BY REGISTRAR <u>10/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>William Cold</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

OCT 8 1956

RECEIVED

10456

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Bethesda</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>Bethesda Md.</u> <u>5721 Grosvenor Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
<u>Clarence</u>						<u>Flickinger</u>	
4. DATE OF DEATH		Month		Day		Year	
<u>Oct.</u>		<u>26</u>		<u>19</u>		<u>56</u>	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
<u>male</u>		<u>white</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>20th July 1874</u>	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>82 yrs.</u>		Months <u>3</u> Days <u>6</u> Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Self-emp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Business</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob Flickinger</u>				14. MOTHER'S MAIDEN NAME <u>Editha Weyrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Queenie Flickinger - Same Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with hemiplegia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>?</u> <u>2 yr.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUG. 5, 1955</u> to <u>OCT. 26, 1956</u> , that I last saw the deceased alive on <u>OCT. 25, 1956</u> , and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Leo M. Curtis</u> M.D. <u>8218 Wisconsin Ave., Bethesda, Md.</u>				<u>10/26/56</u>			
PHYSICIAN'S NAME (Type)							
<u>LEO M. CURTIS</u> M.D. <u>8218 WISCONSIN AVE., BETHESDA, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Bur-transit</u>		<u>10/27/56</u>		<u>Rose Hill</u>		<u>Akron OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
<u>Reft. A. Humphrey</u>				<u>7557 Wisconsin Ave</u>		DATE <u>10/30/56</u>	
24b. REGISTRAR'S SIGNATURE							
<u>Beanie M. Thompson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO. 114

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
RACE		SEX		MARRIAGE	
WHITE		MALE		MARRIED	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		BUSINESS		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SUICIDE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF REGISTRATION		PLACE OF REGISTRATION		OFFICE OF REGISTRATION	
APRIL 11, 1968		BALTIMORE		HEALTH DEPARTMENT	

BUREAU V. 2

NOV 1 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10457
CERTIFICATE OF DEATH

10425

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>-</u> Last <u>FRIEDBERG</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/15/04</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Ida Trilling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>090-10-3201</u>		17. INFORMANT <u>GERTRUDE FRIEDBERG</u> Address <u>11018 Cone Lane SSA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Confluent Bilateral Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic valvular heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9-20</u> , 19 <u>56</u> , to <u>10-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>56</u> , and that death occurred at <u>7P</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris Penny</u>				ADDRESS (Street, city or town, state) <u>11602 Georgia Ave</u>		DATE SIGNED <u>10-2-56</u>	
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldburg Funeral Home</u>				ADDRESS <u>4217-96th St. NW</u>		24a. REC'D BY REGISTRAR <u>10-4-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Denise M. Thompson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SALES REPRESENTATIVE		HEART DISEASE		NATURAL		HOME		JAN 14 1963	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY	
NONE		Chest pain, shortness of breath		Medication, rest		None		None	
DATE OF EXAMINATION		BY PHYSICIAN		BY CORONER		BY JUDGE		BY JURY	
JAN 14 1963		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
ADDRESS OF DECEASED		CITY		STATE		COUNTRY		ZIP CODE	
1234 Main St		BALTIMORE		MD		USA		21201	
DATE OF INTERVIEW		BY AGENT		BY AGENT		BY AGENT		BY AGENT	
JAN 15 1963		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF AGENT		SIGNATURE OF AGENT		SIGNATURE OF AGENT		SIGNATURE OF AGENT		SIGNATURE OF AGENT	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JAN 8 1963
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page, 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10458

CERTIFICATE OF DEATH

10426

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>1614 Myrtle St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>BELLE</u> Last <u>FRONHEISER</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Marshall Skymour</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hinder Powder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Elizabeth Neely</u>	
17. INFORMANT <u>1614-Myrtle St. N.W.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>8 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1948</u> to <u>Oct 6, 1956</u> , that I last saw the deceased alive on <u>Oct 5, 1956</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William T. Saccardi</u> M.D.		ADDRESS (Street, city or town, state) <u>1150 Conn Ave WASH DC</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM T. SACCARDI</u>		DATE SIGNED <u>10/6/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West End Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pottstown, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>		24a. REC'D BY REGISTRAR <u>DATE 10-9-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

BUREAU V. S.

OCT. 11 1956

RECEIVED

10408

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Schuylkill</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takomas Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shenandoah</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Wash San Hosp</u>		d. STREET ADDRESS <u>301 W. Centre St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Halati</u> Last <u>Halati</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u> <u>Italian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-90</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Nicholas Halati</u>		14. MOTHER'S MAIDEN NAME <u>Lotonto</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wash. San Records & Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, pt. old anteur.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart & hypertension</u> DUE TO (c) <u>you</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-4</u> , 19 <u>56</u> , to <u>10-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-6</u> , 19 <u>56</u> , and that death occurred at <u>1205 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas H. Woloton</u>		ADDRESS (Street, city or town, state) <u>7401 Blaine Rd NW</u> DATE SIGNED <u>10/6/56</u>	
PHYSICIAN'S NAME (Type) <u>Chas H Woloton</u>		<u>Nash, D</u>	
22a. BURIAL, CREMATION, REPOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah, Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR <u>10/10/56</u> 24b. REGISTRAR'S SIGNATURE <u>John D. Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

CERTIFICATE OF DEATH

Reg. Dist. No. 223

10409

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 MONTGOMERY AVE</u>				d. STREET ADDRESS <u>12 MONTGOMERY AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>C.</u> Last <u>GARBER</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 20, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. TELEGRAPHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POSTAL TELEGRAPH</u>		11. BIRTHPLACE (State or foreign country) <u>SANGERSVILLE, VA.</u>	
13. FATHER'S NAME <u>DANIEL H. GARBER</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA JANIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROBERT C. GARBER, JR.</u> Address <u>TAKOMA PARK, MD. 12 MONTGOMERY AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of the lung</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Oct. 25, 1955</u> , to <u>10-20-</u> , 1956, that I last saw the deceased alive on <u>10-18-</u> , 1956, and that death occurred at <u>7:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Efrain Guerrero</u> M.D. <u>901</u>				ADDRESS (Street, city or town, state) <u>20th St. N.W. Wash. D.C.</u> DATE SIGNED <u>OCT 20/56</u>			
PHYSICIAN'S NAME (Type) <u>EFRAIN GUERRERO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Hall</u> ADDRESS <u>TAKOMA PARK, D.C. 254 CARROLL ST. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE 10/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10429

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>10459</u> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> <u>13X2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>CEDAR LANE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Gayleard</u> Last <u>Gayleard</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/26/92</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min. <u>63</u>		IF UNDER 24 HRS. Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min. <u>63</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert Asbury Gayleard</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Record (Brother)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>471X</u> <u>Patent bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>471X</u> DUE TO (c) <u>471X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary arteriosclerosis severe</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/17/56</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C.Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR <u>Oct 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude Lawler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATEMENT OF HEATH-BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

OCT 18 1956

RECEIVED

Abdominal brachycephalic

Gravely intracranial necrosis

Henry J. G. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10430

10460

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. STREET ADDRESS 5 Knox Circle, S. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Mitchell Last Gill				4. DATE OF DEATH Month October Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1914	
9. AGE (In years last birthday) 42 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator U. S. Gov't. Printing Office		10b. KIND OF BUSINESS OR INDUSTRY Gov't. Printing Office		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Lafayette Gill				14. MOTHER'S MAIDEN NAME Lilly Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYASTHENIC GRAVIS CRISIS 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA, MILD INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from September 14, 1956 , to October 6, 1956 , that I last saw the deceased alive on October 6, 1956 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Caswell K. Smith M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-6-56			
PHYSICIAN'S NAME (Type) Caswell K. Smith, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/10/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhiner & Co. Washington D.C.				ADDRESS 901-3rd St. N.E.		24a. REC'D BY REGISTRAR DATE 10 1956	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10431

10410

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ukoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hazlettville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>828 Berkshire Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>-</u> Last <u>Gordon</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>196</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-17-09</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Evening Star - Circulation Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Lena Schuman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Chart.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 MYOCARDIAL FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>6 DAYS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>66</u> , to <u>10/15</u> , 19 <u>66</u> ; that I last saw the deceased alive on <u>10/15</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Hanzarsky & Sons, 3501 14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>10/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 22 1956

RECEIVED

10461

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 174 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS RFD #1, Box 222, Fort Hunt Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Virgil Last Gordon				4. DATE OF DEATH Month October Day 24 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21, 1920	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Gordon				14. MOTHER'S MAIDEN NAME Virgie Kidwill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWII (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-14-0895		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart plasmosis, generalized 134.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Histoplasmic, endocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1956 , to October 24, 1956 , that I last saw the deceased alive on October 24, 1956 , and that death occurred at 11:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard K. Merchant, M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 10/25/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) ALEXANDRIA VA.	
23. FUNERAL DIRECTOR'S SIGNATURE J S Early				ADDRESS 809 KING ST. ALEXANDRIA VA		24a. REC'D BY REGISTRAR DATE 1-27-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
RECEIVED		OCT 30 1956	
BUREAU V. S.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10411
CERTIFICATE OF DEATH

10433
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>37 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>513 PHILADELPHIA AVE.</u>			d. STREET ADDRESS <u>513 PHILADELPHIA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>EDGAR</u> Last <u>GOULD</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>4</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 10, 1886</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>EDGAR GOULD</u>			14. MOTHER'S MAIDEN NAME <u>CORA PARKER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>577-42-8328</u>		17. INFORMANT <u>EDNA C. GOULD</u> Address <u>TAKOMA PARK, MD.</u> <u>513 PHILADELPHIA AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>10 years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Coronary Thrombosis March 1956</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Takoma Park, MD</u>			20g. (County) <u>Montgomery</u>		
21. I certify that I attended the deceased from <u>Apr. 10</u> , 19 <u>56</u> , to <u>4 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 Oct</u> , 19 <u>56</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M. B. Queen</u>			ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>4 Oct 1956</u>		
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>			ADDRESS <u>Takoma Park, MD</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>BLADENSBURG RD. PG 606</u>		(State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Hall</u>			ADDRESS <u>TAK. PK. 254 CARROLL ST. NW. C.</u>		24. REC'D BY REGISTRAR <u>10/5/56</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hall</u>					

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED [Faint text]	
SEX [Faint text]	
AGE [Faint text]	
DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]	
CAUSE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF BURIAL OFFICIAL [Faint text]	
SIGNATURE OF CLERK [Faint text]	

BUREAU V. S.

OCT 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10434

10452

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria, Virginia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Box 362, Route #3	
3. NAME OF DECEASED (Type or print) First Ethel Middle Gray Last Gregory		4. DATE OF DEATH Month October Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1908
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietitian		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. C. Shropshire		14. MOTHER'S MAIDEN NAME Dollie Bondurant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 230-20-7516	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) small bowel obstruction (c) fecal fistula proximal to fistula		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 1 yr 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 24, 1956 , to October 5, 1956 , that I last saw the deceased alive on October 5, 1956 , and that death occurred at 10:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred H. Dolan Jr. M.D. National Cancer Institute		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) David C. Nathan Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9-8-56	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Va	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Beamer		24a. REC'D BY REGISTRAR 10-8-56	
ADDRESS Cunningham Funeral Home, Inc.		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		1920-01-15	
Place of Birth		Race		Color		Religion	
New York City		White		White		Roman Catholic	
Usual Residence		Occupation		Education		Marital Status	
123 Main St, Baltimore, Md		Teacher		High School		Married	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural	
Date of Death		Time of Death		Place of Death		Physician	
1956-01-10		10:30 AM		Home		Dr. J. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. M.
JAN 10 1956

RECEIVED

Date of Death		Time of Death		Place of Death		Physician	
1956-01-10		10:30 AM		Home		Dr. J. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

10453

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6020 Delwood Rd</u>				d. STREET ADDRESS <u>6020 Delwood Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>A.</u> Last <u>GUENTHER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 23, 1903</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poughkeepsie, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Grante Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walther Guenther</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma of Lung</u> DUE TO <u>Poquet's Disease of the Breast</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 MONTHS</u> <u>4 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 1</u> , 1956, to <u>OCT. 4</u> , 1956, that I last saw the deceased alive on <u>OCT. 4</u> , 1956, and that death occurred at <u>9:29 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle M.D.</u>				ADDRESS (Street, city or town, state) <u>5009 DEL RAY AVE., BETHESDA, MD.</u>			
DATE SIGNED <u>10/5/56</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Robert G. Angle, 5009 DelRay Ave., Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Tr.</u>		22b. DATE THEREOF <u>10-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poughkeepsie Rural Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Poughkeepsie N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR <u>10-6-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. COOPER		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH August 3, 1956		6. PLACE OF DEATH Home	
7. OCCUPATION None		8. MARITAL STATUS Married		9. BIRTH DATE March 10, 1911		10. BIRTH PLACE Baltimore, Md.		11. US BIRTH Yes		12. FOREIGN BIRTH No	
13. NAME OF FATHER John A. Cooper		14. NAME OF MOTHER Mary A. Cooper		15. NAME OF SPOUSE Elizabeth A. Cooper		16. NAME OF CHILDREN None		17. NAME OF GRANDCHILDREN None		18. NAME OF GREAT-GRANDCHILDREN None	
19. NAME OF DECEASED'S NEXT OF KIN None		20. NAME OF DECEASED'S NEXT OF KIN None		21. NAME OF DECEASED'S NEXT OF KIN None		22. NAME OF DECEASED'S NEXT OF KIN None		23. NAME OF DECEASED'S NEXT OF KIN None		24. NAME OF DECEASED'S NEXT OF KIN None	
25. NAME OF DECEASED'S NEXT OF KIN None		26. NAME OF DECEASED'S NEXT OF KIN None		27. NAME OF DECEASED'S NEXT OF KIN None		28. NAME OF DECEASED'S NEXT OF KIN None		29. NAME OF DECEASED'S NEXT OF KIN None		30. NAME OF DECEASED'S NEXT OF KIN None	
31. NAME OF DECEASED'S NEXT OF KIN None		32. NAME OF DECEASED'S NEXT OF KIN None		33. NAME OF DECEASED'S NEXT OF KIN None		34. NAME OF DECEASED'S NEXT OF KIN None		35. NAME OF DECEASED'S NEXT OF KIN None		36. NAME OF DECEASED'S NEXT OF KIN None	
37. NAME OF DECEASED'S NEXT OF KIN None		38. NAME OF DECEASED'S NEXT OF KIN None		39. NAME OF DECEASED'S NEXT OF KIN None		40. NAME OF DECEASED'S NEXT OF KIN None		41. NAME OF DECEASED'S NEXT OF KIN None		42. NAME OF DECEASED'S NEXT OF KIN None	
43. NAME OF DECEASED'S NEXT OF KIN None		44. NAME OF DECEASED'S NEXT OF KIN None		45. NAME OF DECEASED'S NEXT OF KIN None		46. NAME OF DECEASED'S NEXT OF KIN None		47. NAME OF DECEASED'S NEXT OF KIN None		48. NAME OF DECEASED'S NEXT OF KIN None	
49. NAME OF DECEASED'S NEXT OF KIN None		50. NAME OF DECEASED'S NEXT OF KIN None		51. NAME OF DECEASED'S NEXT OF KIN None		52. NAME OF DECEASED'S NEXT OF KIN None		53. NAME OF DECEASED'S NEXT OF KIN None		54. NAME OF DECEASED'S NEXT OF KIN None	
55. NAME OF DECEASED'S NEXT OF KIN None		56. NAME OF DECEASED'S NEXT OF KIN None		57. NAME OF DECEASED'S NEXT OF KIN None		58. NAME OF DECEASED'S NEXT OF KIN None		59. NAME OF DECEASED'S NEXT OF KIN None		60. NAME OF DECEASED'S NEXT OF KIN None	
61. NAME OF DECEASED'S NEXT OF KIN None		62. NAME OF DECEASED'S NEXT OF KIN None		63. NAME OF DECEASED'S NEXT OF KIN None		64. NAME OF DECEASED'S NEXT OF KIN None		65. NAME OF DECEASED'S NEXT OF KIN None		66. NAME OF DECEASED'S NEXT OF KIN None	
67. NAME OF DECEASED'S NEXT OF KIN None		68. NAME OF DECEASED'S NEXT OF KIN None		69. NAME OF DECEASED'S NEXT OF KIN None		70. NAME OF DECEASED'S NEXT OF KIN None		71. NAME OF DECEASED'S NEXT OF KIN None		72. NAME OF DECEASED'S NEXT OF KIN None	
73. NAME OF DECEASED'S NEXT OF KIN None		74. NAME OF DECEASED'S NEXT OF KIN None		75. NAME OF DECEASED'S NEXT OF KIN None		76. NAME OF DECEASED'S NEXT OF KIN None		77. NAME OF DECEASED'S NEXT OF KIN None		78. NAME OF DECEASED'S NEXT OF KIN None	
79. NAME OF DECEASED'S NEXT OF KIN None		80. NAME OF DECEASED'S NEXT OF KIN None		81. NAME OF DECEASED'S NEXT OF KIN None		82. NAME OF DECEASED'S NEXT OF KIN None		83. NAME OF DECEASED'S NEXT OF KIN None		84. NAME OF DECEASED'S NEXT OF KIN None	
85. NAME OF DECEASED'S NEXT OF KIN None		86. NAME OF DECEASED'S NEXT OF KIN None		87. NAME OF DECEASED'S NEXT OF KIN None		88. NAME OF DECEASED'S NEXT OF KIN None		89. NAME OF DECEASED'S NEXT OF KIN None		90. NAME OF DECEASED'S NEXT OF KIN None	
91. NAME OF DECEASED'S NEXT OF KIN None		92. NAME OF DECEASED'S NEXT OF KIN None		93. NAME OF DECEASED'S NEXT OF KIN None		94. NAME OF DECEASED'S NEXT OF KIN None		95. NAME OF DECEASED'S NEXT OF KIN None		96. NAME OF DECEASED'S NEXT OF KIN None	
97. NAME OF DECEASED'S NEXT OF KIN None		98. NAME OF DECEASED'S NEXT OF KIN None		99. NAME OF DECEASED'S NEXT OF KIN None		100. NAME OF DECEASED'S NEXT OF KIN None		101. NAME OF DECEASED'S NEXT OF KIN None		102. NAME OF DECEASED'S NEXT OF KIN None	
103. NAME OF DECEASED'S NEXT OF KIN None		104. NAME OF DECEASED'S NEXT OF KIN None		105. NAME OF DECEASED'S NEXT OF KIN None		106. NAME OF DECEASED'S NEXT OF KIN None		107. NAME OF DECEASED'S NEXT OF KIN None		108. NAME OF DECEASED'S NEXT OF KIN None	
109. NAME OF DECEASED'S NEXT OF KIN None		110. NAME OF DECEASED'S NEXT OF KIN None		111. NAME OF DECEASED'S NEXT OF KIN None		112. NAME OF DECEASED'S NEXT OF KIN None		113. NAME OF DECEASED'S NEXT OF KIN None		114. NAME OF DECEASED'S NEXT OF KIN None	
115. NAME OF DECEASED'S NEXT OF KIN None		116. NAME OF DECEASED'S NEXT OF KIN None		117. NAME OF DECEASED'S NEXT OF KIN None		118. NAME OF DECEASED'S NEXT OF KIN None		119. NAME OF DECEASED'S NEXT OF KIN None		120. NAME OF DECEASED'S NEXT OF KIN None	

BUREAU V. S.

OCT 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10436

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, 14, Md.		c. LENGTH OF STAY IN 1b 129 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3652 Gunston Road	
3. NAME OF DECEASED (Type or print) First Davis Middle Fraser Last Hall		4. DATE OF DEATH Month October Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1937
9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Hall		14. MOTHER'S MAIDEN NAME Helen Fraser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 230-48-9105	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory & Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain stem Compression DUE TO (c) Brain Tumor Unspecified Type.			INTERVAL BETWEEN ONSET AND DEATH 1/55.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25, 1956 , to October 1, 1956 , that I last saw the deceased alive on October 1, 1956 and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Lane		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 10/1/56 National Institutes of Health Bethesda 14, Md.	
PHYSICIAN'S NAME (Type) John F. Lane, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 10/2/56	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) SUITLAND MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE W. BEATLEY FUNERAL HOME 809 KING ST ALEXANDRIA J. S. Overly		24a. REC'D BY REGISTRAR ME-4-56 VIRGINIA	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

CERTIFICATE OF DEATH

Name of Deceased John F. Jones, Jr.		Sex Male		Age 45		Date of Birth Jan 1, 1913		Place of Birth Baltimore, Md.	
Cause of Death Myocardial Infarction		Duration of Illness 2 days		Date of Death Jan 1, 1956		Place of Death Home		Signature of Physician [Signature]	
Occupation Salesman		Marital Status Married		Education High School		Religion Roman Catholic		Signature of Informant [Signature]	
Address 1234 Main St., Baltimore, Md.		Residence Same as above		Usual Place of Abode Same as above		Usual Place of Work Same as above		Signature of Informant [Signature]	
Date of Report Jan 1, 1956		Reported by [Signature]		Signature of Registrar [Signature]		Signature of Medical Officer [Signature]		Signature of Health Officer [Signature]	

BUREAU V. B.

OCT 8 1956

RECEIVED

10465

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>2725 Terrace Rd. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>CHRISTINE</u> Middle Last <u>HAMILTON</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1862</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <u>10</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Silver Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Heigel</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Abendschein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Ann Boyd</u>		Address <u>2760 Rand Pl. N.E. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 12, 1956</u> to <u>OCT. 24</u> , 1956, that I last saw the deceased alive on <u>OCT. 24</u> , 1956, and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5206 NORWAY DR. OCT 24, 1956</u>							
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.				PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u> <u>CHEVY CHASE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Brittland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

RECEIVED

OCT 29 1956

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10	
CERTIFICATE OF DEATH	
See Form 10	
1. Name of Deceased	
2. Sex	
3. Date of Birth	
4. Place of Birth	
5. Date of Death	
6. Place of Death	
7. Cause of Death	
8. Manner of Death	
9. Signature of Physician	
10. Signature of Registrar	
11. Date of Registration	
12. Place of Registration	
13. Name of Registrar	
14. Signature of Registrar	
15. Date of Registration	
16. Place of Registration	
17. Name of Registrar	
18. Signature of Registrar	
19. Date of Registration	
20. Place of Registration	
21. Name of Registrar	
22. Signature of Registrar	
23. Date of Registration	
24. Place of Registration	
25. Name of Registrar	
26. Signature of Registrar	
27. Date of Registration	
28. Place of Registration	
29. Name of Registrar	
30. Signature of Registrar	
31. Date of Registration	
32. Place of Registration	
33. Name of Registrar	
34. Signature of Registrar	
35. Date of Registration	
36. Place of Registration	
37. Name of Registrar	
38. Signature of Registrar	
39. Date of Registration	
40. Place of Registration	
41. Name of Registrar	
42. Signature of Registrar	
43. Date of Registration	
44. Place of Registration	
45. Name of Registrar	
46. Signature of Registrar	
47. Date of Registration	
48. Place of Registration	
49. Name of Registrar	
50. Signature of Registrar	
51. Date of Registration	
52. Place of Registration	
53. Name of Registrar	
54. Signature of Registrar	
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81. Name of Registrar	
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84. Place of Registration	
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86. Signature of Registrar	
87. Date of Registration	
88. Place of Registration	
89. Name of Registrar	
90. Signature of Registrar	
91. Date of Registration	
92. Place of Registration	
93. Name of Registrar	
94. Signature of Registrar	
95. Date of Registration	
96. Place of Registration	
97. Name of Registrar	
98. Signature of Registrar	
99. Date of Registration	
100. Place of Registration	

10466

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6818 Delaware Street		d. STREET ADDRESS 6818 Delaware Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Pennington Last Hanback		4. DATE OF DEATH Month October Day 12 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Constructing	11. BIRTHPLACE (State or foreign country) Warrenton, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Hanback		14. MOTHER'S MAIDEN NAME Margaret Hitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles W. Hanback, 6818 Delaware St. D.C. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 54 , to Oct 12 , 19 56 , that I last saw the deceased alive on Sept 15 , 19 56 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul D. Cantor		ADDRESS (Street, city or town, state) 4709 Montgomery Lane Bethesda Md	
PHYSICIAN'S NAME (Type) Paul D. Cantor		DATE SIGNED 10/12/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10/15/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 10-15-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

OCT 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10428

CERTIFICATE OF DEATH

10439

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rockville Congressional Manor Sanitarium				d. STREET ADDRESS 5725 Utah Ave., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Iva Mabel Hedges				4. DATE OF DEATH Month October Day 4 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/1881	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Casey, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Freeman				14. MOTHER'S MAIDEN NAME Elizabeth Puffner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Records at Congressional Manor Sanitarium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mos years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 1956 to Oct 4, 1956 , that I last saw the deceased alive on Oct 4, 1956 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Havell M.D.				ADDRESS (Street, city or town, state) 5516 Nebraska Ave Washington DC			
DATE SIGNED 10-4-56							
PHYSICIAN'S NAME (Type) Robert B. Havell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Himes Co.				ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR 0018	
24b. REGISTRAR'S SIGNATURE Laurel Knight				DATE 1956			

CERTIFICATE OF DEATH

NAME OF DECEASED John D. Johnson		DATE OF BIRTH 1/1/1900		PLACE OF BIRTH Boston, Mass.	
RESIDENCE 123 Main St., Boston, Mass.		OCCUPATION Clerk		CAUSE OF DEATH Heart Disease	
DATE OF DEATH 1/15/1956		PLACE OF DEATH Home		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF DECEASED [Signature]	
DATE OF SIGNATURE 1/15/1956		DATE OF SIGNATURE 1/15/1956		DATE OF SIGNATURE 1/15/1956	

BUREAU V. 3

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

10457

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9810 GEORGIA AVE.</u>				d. STREET ADDRESS <u>123 W. LAFAYETTE AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>FLORENCE</u> Last <u>HEWITT</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-8-1872</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN G. HOOK</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA ERICH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DOROTHY GRANN</u> Address <u>5620 COLORADO AVE WASHINGTON, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>SENILITY</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u></u> Year <u></u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 5</u> , 19 <u>51</u> , to <u>OCT. 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT. 24</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry M. Howden</u> M.D.				ADDRESS (Street, city or town, state) <u>5206 NORWAY DR.</u>		DATE SIGNED <u>10/4/56</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. HOWDEN</u>				<u>CHEVY CHASE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10/26/56</u>		<u>GREENMOUNT</u>		<u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 1400 Chapin St NW</u>				24a. REC'D BY REGISTRAR <u>10/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Teller</u>	

BUREAU V. 8

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10441

10458

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>BLAIR</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TYRONE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San</u>		d. STREET ADDRESS <u>F. & M. BANK BUILDING</u> <u>XXXXXXXXXXXXXXXXXX</u>	
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>S</u> Last <u>Hiltner</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug - 4 - 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CLERK, RAILWAY</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>TYRONE, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Hiltner</u>		14. MOTHER'S MAIDEN NAME <u>Emma James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Robert P. Hiltner</u>		Address <u>100 Northwood Ave. S. S. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u> <u>350x</u> DUE TO (b) <u>Parkinson's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>10-12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 Aug</u> , 19 <u>55</u> , to <u>21 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-21</u> , 19 <u>56</u> , and that death occurred at <u>2:52 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Queen</u>		DATE SIGNED <u>7112 Willow Ave 22 Oct 1956</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>10/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRANDVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>TYRONE, BLAIR COUNTY, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>10/23/56</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Little</u>	

9561 26 130

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10469

CERTIFICATE OF DEATH

Reg. Dist. No.

10442

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>M. Capitola Hobbs</u>		4. DATE OF DEATH <u>October 25 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk U.S. Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James L. Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Burtonsville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Severe Coronary Arterial Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>October 25 1956</u> , that I last saw the deceased alive on <u>October 25 1956</u> , and that death occurred at <u>Laurel, Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u>		M.D. <u>Laurel, Maryland</u> DATE SIGNED <u>Oct. 29 1956</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Seigland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Canfield</u>		ADDRESS <u>Laurel, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Bertie B. Lawler</u>	
DATE <u>10-30-56</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 10 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CITY AND COUNTY <i>Baltimore City</i>		8. STATE <i>Md.</i>		9. ZIP CODE <i>21201</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John J. Brown</i>		17. SIGNATURE OF WITNESS <i>John J. Brown</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>	
19. SIGNATURE OF DECEASED <i>John J. Brown</i>		20. SIGNATURE OF WITNESS <i>John J. Brown</i>		21. SIGNATURE OF DECEASED <i>John J. Brown</i>	
22. SIGNATURE OF DECEASED <i>John J. Brown</i>		23. SIGNATURE OF WITNESS <i>John J. Brown</i>		24. SIGNATURE OF DECEASED <i>John J. Brown</i>	
25. SIGNATURE OF DECEASED <i>John J. Brown</i>		26. SIGNATURE OF WITNESS <i>John J. Brown</i>		27. SIGNATURE OF DECEASED <i>John J. Brown</i>	
28. SIGNATURE OF DECEASED <i>John J. Brown</i>		29. SIGNATURE OF WITNESS <i>John J. Brown</i>		30. SIGNATURE OF DECEASED <i>John J. Brown</i>	
31. SIGNATURE OF DECEASED <i>John J. Brown</i>		32. SIGNATURE OF WITNESS <i>John J. Brown</i>		33. SIGNATURE OF DECEASED <i>John J. Brown</i>	
34. SIGNATURE OF DECEASED <i>John J. Brown</i>		35. SIGNATURE OF WITNESS <i>John J. Brown</i>		36. SIGNATURE OF DECEASED <i>John J. Brown</i>	
37. SIGNATURE OF DECEASED <i>John J. Brown</i>		38. SIGNATURE OF WITNESS <i>John J. Brown</i>		39. SIGNATURE OF DECEASED <i>John J. Brown</i>	
40. SIGNATURE OF DECEASED <i>John J. Brown</i>		41. SIGNATURE OF WITNESS <i>John J. Brown</i>		42. SIGNATURE OF DECEASED <i>John J. Brown</i>	
43. SIGNATURE OF DECEASED <i>John J. Brown</i>		44. SIGNATURE OF WITNESS <i>John J. Brown</i>		45. SIGNATURE OF DECEASED <i>John J. Brown</i>	
46. SIGNATURE OF DECEASED <i>John J. Brown</i>		47. SIGNATURE OF WITNESS <i>John J. Brown</i>		48. SIGNATURE OF DECEASED <i>John J. Brown</i>	
49. SIGNATURE OF DECEASED <i>John J. Brown</i>		50. SIGNATURE OF WITNESS <i>John J. Brown</i>		51. SIGNATURE OF DECEASED <i>John J. Brown</i>	
52. SIGNATURE OF DECEASED <i>John J. Brown</i>		53. SIGNATURE OF WITNESS <i>John J. Brown</i>		54. SIGNATURE OF DECEASED <i>John J. Brown</i>	
55. SIGNATURE OF DECEASED <i>John J. Brown</i>		56. SIGNATURE OF WITNESS <i>John J. Brown</i>		57. SIGNATURE OF DECEASED <i>John J. Brown</i>	
58. SIGNATURE OF DECEASED <i>John J. Brown</i>		59. SIGNATURE OF WITNESS <i>John J. Brown</i>		60. SIGNATURE OF DECEASED <i>John J. Brown</i>	
61. SIGNATURE OF DECEASED <i>John J. Brown</i>		62. SIGNATURE OF WITNESS <i>John J. Brown</i>		63. SIGNATURE OF DECEASED <i>John J. Brown</i>	
64. SIGNATURE OF DECEASED <i>John J. Brown</i>		65. SIGNATURE OF WITNESS <i>John J. Brown</i>		66. SIGNATURE OF DECEASED <i>John J. Brown</i>	
67. SIGNATURE OF DECEASED <i>John J. Brown</i>		68. SIGNATURE OF WITNESS <i>John J. Brown</i>		69. SIGNATURE OF DECEASED <i>John J. Brown</i>	
70. SIGNATURE OF DECEASED <i>John J. Brown</i>		71. SIGNATURE OF WITNESS <i>John J. Brown</i>		72. SIGNATURE OF DECEASED <i>John J. Brown</i>	
73. SIGNATURE OF DECEASED <i>John J. Brown</i>		74. SIGNATURE OF WITNESS <i>John J. Brown</i>		75. SIGNATURE OF DECEASED <i>John J. Brown</i>	
76. SIGNATURE OF DECEASED <i>John J. Brown</i>		77. SIGNATURE OF WITNESS <i>John J. Brown</i>		78. SIGNATURE OF DECEASED <i>John J. Brown</i>	
79. SIGNATURE OF DECEASED <i>John J. Brown</i>		80. SIGNATURE OF WITNESS <i>John J. Brown</i>		81. SIGNATURE OF DECEASED <i>John J. Brown</i>	
82. SIGNATURE OF DECEASED <i>John J. Brown</i>		83. SIGNATURE OF WITNESS <i>John J. Brown</i>		84. SIGNATURE OF DECEASED <i>John J. Brown</i>	
85. SIGNATURE OF DECEASED <i>John J. Brown</i>		86. SIGNATURE OF WITNESS <i>John J. Brown</i>		87. SIGNATURE OF DECEASED <i>John J. Brown</i>	
88. SIGNATURE OF DECEASED <i>John J. Brown</i>		89. SIGNATURE OF WITNESS <i>John J. Brown</i>		90. SIGNATURE OF DECEASED <i>John J. Brown</i>	
91. SIGNATURE OF DECEASED <i>John J. Brown</i>		92. SIGNATURE OF WITNESS <i>John J. Brown</i>		93. SIGNATURE OF DECEASED <i>John J. Brown</i>	
94. SIGNATURE OF DECEASED <i>John J. Brown</i>		95. SIGNATURE OF WITNESS <i>John J. Brown</i>		96. SIGNATURE OF DECEASED <i>John J. Brown</i>	
97. SIGNATURE OF DECEASED <i>John J. Brown</i>		98. SIGNATURE OF WITNESS <i>John J. Brown</i>		99. SIGNATURE OF DECEASED <i>John J. Brown</i>	
100. SIGNATURE OF DECEASED <i>John J. Brown</i>		101. SIGNATURE OF WITNESS <i>John J. Brown</i>		102. SIGNATURE OF DECEASED <i>John J. Brown</i>	

BUREAU V. 8

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

CERTIFICATE OF DEATH

Reg. Dist. No. 2/7

10443

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital		e. STREET ADDRESS Holsey Road	
3. NAME OF DECEASED (Type or print) First Horace Middle S. Last Holsey		4. DATE OF DEATH Month October Day 6 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Montg. Co., Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Holsey		14. MOTHER'S MAIDEN NAME Catherine Potts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Emma F. Butler, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Arteriosclerosis - generalized c Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hours ? years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1956 , to October 6, 1956 , that I last saw the deceased alive on October 6, 19 56 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. McKendree Boyer, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Druid Theatre Building 10-7-56 Damascus, Maryland.	
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Friendship		22d. LOCATION (City, town, or county) (State) Nr. Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McLeavorth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE 10-10-56		24b. REGISTRAR'S SIGNATURE Kentucky B. Lawler	

10471

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 124 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Letha Middle Levine Last Holton		4. DATE OF DEATH Month October Day 21 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 28, 1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Waitress Work	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Money		14. MOTHER'S MAIDEN NAME Lena Dillard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-16-6375	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of the ovary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) uremia DUE TO (c) cancer INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 8 , 19 56 , to October 21 , 19 56 , that I last saw the deceased alive on October 21 , 19 56 , and that death occurred at 4:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 10-22-56 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE David G. Nathan, M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	10-24-56	MONTE VISTA	BLUEFIELD WEST VA
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		24a. REC'D BY REGISTRAR 10-24-56	
ADDRESS 1400 Chapin Street		24b. REGISTRAR'S SIGNATURE Beane M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

1956 23 10

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10472

CERTIFICATE OF DEATH

10445

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 112 S. Boots Street	
3. NAME OF DECEASED (Type or print) First Robert Middle Mason Last HOSEA		4. DATE OF DEATH Month October Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drug Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Co.	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert C. Hosea		14. MOTHER'S MAIDEN NAME Blanche Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son) Robert Chambers Hosea (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenoma of pituitary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 August 19 56 , to 10 October 19 56 , that I last saw the deceased alive on 10 October 19 56 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.H. Drickemiller M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 10-11-56	
PHYSICIAN'S NAME (Type) W.H. DRICKEMILLER, CAPT.MC,USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56	
22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Marion, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 10-11-56		24b. REGISTRAR'S SIGNATURE Mary E. Carvelly	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-1-21		6. BIRTH PLACE MOBILE, ALA.	
7. MARRIAGE Single		8. OCCUPATION None		9. RESIDENCE 1111 N. W. 11th St., Baltimore, Md.	
10. DATE OF DEATH 10-1-68		11. TIME OF DEATH 10:00 AM		12. PLACE OF DEATH Home	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. MEDICAL HISTORY None	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESSES (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JURY (None)		21. SIGNATURE OF STATE DEPARTMENT OF HEALTH (None)	

BUREAU V. 81

OCT 15 1968

RECEIVED

10473

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PATRICK</u> First <u>HOWARD</u> Middle <u>HOWARD</u> Last				4. DATE OF DEATH <u>10-11</u> 19 <u>56</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-65</u> 91 yrs.	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Scmfg.-Foreman</u>			
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>THOMAS HOWARD</u>				14. MOTHER'S MAIDEN NAME <u>Ann Lynn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>204-20-6380 A</u>			
17. INFORMANT <u>Mrs. Mary Boone - nee</u> Address <u>3001 Fernside St. Kensington, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 570.5 DUE TO (b) <u>Intestinal Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma sigmoid</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>Oct 11 1956</u> Hour a. m. <u>2:50</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCT 5</u> , 19 <u>56</u> , to <u>OCT 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>OCT 10</u> , 19 <u>56</u> , and that death occurred at <u>2:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. Haberlin</u> M.D.				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN P. HABERLIN</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>				22b. DATE THEREOF <u>10/15/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARK'S CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>BRISTOL, BUCKS COUNTY, PA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>10-15-56</u>			
				24b. REGISTRAR'S SIGNATURE <u>Rebecca M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10474

CERTIFICATE OF DEATH

10447

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>906 Wade Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Pauline MARY HUNT</u>				4. DATE OF DEATH <u>10 - 21 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-14-94</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Edward Leonard</u>				14. MOTHER'S MAIDEN NAME <u>MARY MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>443x</u>			
17. INFORMANT <u>Joseph Hunt - Husband</u>				Address <u>906 Wade Ave Rockville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural Effusion, Bil. (1500cc)</u>						<u>1 week</u>	
DUE TO (b) <u>Asperteric Heart Disease & Cardiomegaly</u>						<u>3 years</u>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/20/56</u> , 19 <u>56</u> , to <u>10/21/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/21/56</u> , 19 <u>56</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u>				ADDRESS (Street, city or town, state) <u>Rockville, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones, M.D.</u>				DATE SIGNED <u>10/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Hamilton Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Humphrey</u>				ADDRESS <u>Bethesda Md</u>			
24a. REC'D BY REGISTRAR <u>DATE 24 56</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>James Stephen V. Jones</i>		2. SEX <i>Male</i>		3. AGE <i>31</i>	
4. DATE OF BIRTH <i>1934</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>	
7. CITY OF DEATH <i>Baltimore, Md.</i>		8. COUNTY OF DEATH <i>Baltimore</i>		9. STATE OF DEATH <i>Md.</i>	
10. DATE OF DEATH <i>1965</i>		11. TIME OF DEATH <i>11:00 AM</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. MEDICAL ATTENDANT <i>Dr. [illegible]</i>	
16. SIGNATURE OF DECEASED <i>[illegible]</i>		17. SIGNATURE OF WITNESS <i>[illegible]</i>		18. SIGNATURE OF DECEASED <i>[illegible]</i>	
19. SIGNATURE OF DECEASED <i>[illegible]</i>		20. SIGNATURE OF DECEASED <i>[illegible]</i>		21. SIGNATURE OF DECEASED <i>[illegible]</i>	
22. SIGNATURE OF DECEASED <i>[illegible]</i>		23. SIGNATURE OF DECEASED <i>[illegible]</i>		24. SIGNATURE OF DECEASED <i>[illegible]</i>	
25. SIGNATURE OF DECEASED <i>[illegible]</i>		26. SIGNATURE OF DECEASED <i>[illegible]</i>		27. SIGNATURE OF DECEASED <i>[illegible]</i>	
28. SIGNATURE OF DECEASED <i>[illegible]</i>		29. SIGNATURE OF DECEASED <i>[illegible]</i>		30. SIGNATURE OF DECEASED <i>[illegible]</i>	
31. SIGNATURE OF DECEASED <i>[illegible]</i>		32. SIGNATURE OF DECEASED <i>[illegible]</i>		33. SIGNATURE OF DECEASED <i>[illegible]</i>	
34. SIGNATURE OF DECEASED <i>[illegible]</i>		35. SIGNATURE OF DECEASED <i>[illegible]</i>		36. SIGNATURE OF DECEASED <i>[illegible]</i>	
37. SIGNATURE OF DECEASED <i>[illegible]</i>		38. SIGNATURE OF DECEASED <i>[illegible]</i>		39. SIGNATURE OF DECEASED <i>[illegible]</i>	
40. SIGNATURE OF DECEASED <i>[illegible]</i>		41. SIGNATURE OF DECEASED <i>[illegible]</i>		42. SIGNATURE OF DECEASED <i>[illegible]</i>	
43. SIGNATURE OF DECEASED <i>[illegible]</i>		44. SIGNATURE OF DECEASED <i>[illegible]</i>		45. SIGNATURE OF DECEASED <i>[illegible]</i>	
46. SIGNATURE OF DECEASED <i>[illegible]</i>		47. SIGNATURE OF DECEASED <i>[illegible]</i>		48. SIGNATURE OF DECEASED <i>[illegible]</i>	
49. SIGNATURE OF DECEASED <i>[illegible]</i>		50. SIGNATURE OF DECEASED <i>[illegible]</i>		51. SIGNATURE OF DECEASED <i>[illegible]</i>	
52. SIGNATURE OF DECEASED <i>[illegible]</i>		53. SIGNATURE OF DECEASED <i>[illegible]</i>		54. SIGNATURE OF DECEASED <i>[illegible]</i>	
55. SIGNATURE OF DECEASED <i>[illegible]</i>		56. SIGNATURE OF DECEASED <i>[illegible]</i>		57. SIGNATURE OF DECEASED <i>[illegible]</i>	
58. SIGNATURE OF DECEASED <i>[illegible]</i>		59. SIGNATURE OF DECEASED <i>[illegible]</i>		60. SIGNATURE OF DECEASED <i>[illegible]</i>	
61. SIGNATURE OF DECEASED <i>[illegible]</i>		62. SIGNATURE OF DECEASED <i>[illegible]</i>		63. SIGNATURE OF DECEASED <i>[illegible]</i>	
64. SIGNATURE OF DECEASED <i>[illegible]</i>		65. SIGNATURE OF DECEASED <i>[illegible]</i>		66. SIGNATURE OF DECEASED <i>[illegible]</i>	
67. SIGNATURE OF DECEASED <i>[illegible]</i>		68. SIGNATURE OF DECEASED <i>[illegible]</i>		69. SIGNATURE OF DECEASED <i>[illegible]</i>	
70. SIGNATURE OF DECEASED <i>[illegible]</i>		71. SIGNATURE OF DECEASED <i>[illegible]</i>		72. SIGNATURE OF DECEASED <i>[illegible]</i>	
73. SIGNATURE OF DECEASED <i>[illegible]</i>		74. SIGNATURE OF DECEASED <i>[illegible]</i>		75. SIGNATURE OF DECEASED <i>[illegible]</i>	
76. SIGNATURE OF DECEASED <i>[illegible]</i>		77. SIGNATURE OF DECEASED <i>[illegible]</i>		78. SIGNATURE OF DECEASED <i>[illegible]</i>	
79. SIGNATURE OF DECEASED <i>[illegible]</i>		80. SIGNATURE OF DECEASED <i>[illegible]</i>		81. SIGNATURE OF DECEASED <i>[illegible]</i>	
82. SIGNATURE OF DECEASED <i>[illegible]</i>		83. SIGNATURE OF DECEASED <i>[illegible]</i>		84. SIGNATURE OF DECEASED <i>[illegible]</i>	
85. SIGNATURE OF DECEASED <i>[illegible]</i>		86. SIGNATURE OF DECEASED <i>[illegible]</i>		87. SIGNATURE OF DECEASED <i>[illegible]</i>	
88. SIGNATURE OF DECEASED <i>[illegible]</i>		89. SIGNATURE OF DECEASED <i>[illegible]</i>		90. SIGNATURE OF DECEASED <i>[illegible]</i>	
91. SIGNATURE OF DECEASED <i>[illegible]</i>		92. SIGNATURE OF DECEASED <i>[illegible]</i>		93. SIGNATURE OF DECEASED <i>[illegible]</i>	
94. SIGNATURE OF DECEASED <i>[illegible]</i>		95. SIGNATURE OF DECEASED <i>[illegible]</i>		96. SIGNATURE OF DECEASED <i>[illegible]</i>	
97. SIGNATURE OF DECEASED <i>[illegible]</i>		98. SIGNATURE OF DECEASED <i>[illegible]</i>		99. SIGNATURE OF DECEASED <i>[illegible]</i>	
100. SIGNATURE OF DECEASED <i>[illegible]</i>		101. SIGNATURE OF DECEASED <i>[illegible]</i>		102. SIGNATURE OF DECEASED <i>[illegible]</i>	

BUREAU V. S.

1965 OCT 28

RECEIVED

RECEIVED IN PUBLIC DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10412

CERTIFICATE OF DEATH

10448

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN TB <u>8 hrs - 47 min</u>				d. STREET ADDRESS <u>7501 Flower Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ignatius</u>				4. DATE OF DEATH Month Day Year <u>October 2 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 56</u>		9. AGE (In years last birthday) yrs. <u>8</u> Min. <u>47</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph LeRoy Ignatius</u>				14. MOTHER'S MAIDEN NAME <u>Anita Janet Louisa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mother - 7501 Flower Ave, Takoma Park, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Prematurity (gestation age 28 weeks by measurement)</u> DUE TO (b) <u>Incompetence of placenta & lungs</u> DUE TO (c) <u>asphyxiation Venous congestion pulmonary edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-2-56</u> , 19 <u>56</u> , to <u>10-2-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-2-56</u> , 19 <u>56</u> , and that death occurred at <u>9:40 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>10-21-56</u>							
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Ruth Standard, M.D. Washington Sanitarium and Hospital, Takoma Park, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. San. & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Hare, MD. Washington San & Hospital Takoma Park, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Doherty</u>	

2075192 XV 1

RECEIVED

OCT 24 1956

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESS: [illegible]
12. SIGNATURE OF DOCTOR: [illegible]
13. SIGNATURE OF REGISTRAR: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Bethesda, Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Bethesda Suburban Hospital</u>		d. STREET ADDRESS <u>5022 Alta Vista Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>Leigh</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>-31</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-02</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arthur V. Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband</u>		Address <u>Dr. Fritz R. Jackson, 5022 Alta Vista Rd Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Lt. Ventricle</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis, Circumflex</u> DUE TO <u>Intercoronary</u> (c) <u>Intercoronary</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 29</u> , 19 <u>56</u> , to <u>Oct. 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 31</u> , 19 <u>56</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4861 Battery Lane, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles J. Savarese, Jr.</u>		DATE SIGNED <u>4861 Battery Lane, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-2-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 2 NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10450
27/3

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 10413 MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 115 Lincoln Ave				d. STREET ADDRESS 115 Lincoln Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First William Middle Jordan Last				4. DATE OF DEATH Month 10/9/56 Day Year 19															
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/31/88		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Miss.				11. BIRTHPLACE (State or foreign country) USA											
13. FATHER'S NAME Phillip Jordan						14. MOTHER'S MAIDEN NAME unknown													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.				17. INFORMANT Lee A. Jordan Address 28 Ritchie Ave., Silver Springs, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED 10/11/56							
EXAMINER'S NAME (Type) Frank J. Broschart				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 10/13/56		22c. NAME OF CEMETERY OR CREMATORY Ash Momprial Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden ADDRESS Rockville, Md.												24a. REC'D. BY REGISTRAR OCT 17 1956		24b. REGISTRAR'S SIGNATURE J. Wilson Duddy					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10451

10476

CERTIFICATE OF DEATH

Reg. Dist. No.

276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1821 P Street, S. E.	
3. NAME OF DECEASED (Type or print) First Lula Middle Mae Last Joyner		4. DATE OF DEATH Month October Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1888
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Ramsey		14. MOTHER'S MAIDEN NAME Mary J. Letchworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelocytic Leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 18, 1956 , to October 12, 1956 , that I last saw the deceased alive on October 12, 1956 , and that death occurred at 7:12 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard R. Engel		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Howard R. Engel, M. D.		DATE SIGNED 10/12/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Oct 12, 1956	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) ALEXANDRIA VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Exley		ADDRESS 809 King St. ALEXANDRIA VA.	24a. REC'D BY REGISTRAR DATE 11-17-56
		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

OCT 18 1956

RECEIVED

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10477

CERTIFICATE OF DEATH

10452

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 20 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5911 LeMay Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Kephart</u> Last <u>Kephart</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Milton Cithen</u>		14. MOTHER'S MAIDEN NAME <u>Allen Gayne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Allen A. Rossignol</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> <u>bronchopneumonia, L. h. bil -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic Rheumatic Heart Disease and</u> (c) <u>Mitral Valvulitis & Cor pulmonale</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholecystitis & cholelithiasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 Oct., 1956</u> , to <u>29 Oct., 1956</u> , that I last saw the deceased alive on <u>28 Oct., 1956</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Suburban Hospital</u>	
PHYSICIAN'S NAME (Type) <u>J. E. ASH</u>		DATE SIGNED <u>29 Oct 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Leesburg Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>10-31-56</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

BUREAU V. 2

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SECTION

Union

10/11/56

1956

10/11/56 10/11/56 10/11/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10453

10478

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8031 EASTERN AVENUE		d. STREET ADDRESS 8031 EASTERN AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PHILIP Middle B. Last KEY		4. DATE OF DEATH Month OCTOBER Day 25 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/88
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE (own business)		10b. KIND OF BUSINESS OR INDUSTRY FREDERICK, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM T. KEY		14. MOTHER'S MAIDEN NAME JOSEPHINE BALTZELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-09-3631	
17. INFORMANT Mr. Philip B. Key, Jr., #3 Pooks Hill Rd. Bethesda, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma. 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder with liver metastases DUE TO (c) 10 months INTERVAL BETWEEN ONSET AND DEATH 6 hours.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis, acute.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 , 19 54 , to October , 19 56 , that I last saw the deceased alive on 25 Oct. , 19 56 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 929 Penshing Drive, Silver Spring, Md. DATE SIGNED 10/29/56			
ACTUAL SIGNATURE Seruch T. Kimble M.D.		PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/29/56	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Harner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 10/29/56	
24b. REGISTRAR'S SIGNATURE Francis C. [Signature]			

NOV 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454

10479

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>74</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brown 74</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS-SAM</u>				d. STREET ADDRESS <u>720 Hunts Point Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>MALKINA</u> Middle <u>(KOENIG)</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Buda-pest-Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Bernard Hochdort</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Albert King 720 Hunts Point Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>56</u> , to <u>10/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/8</u> , 19 <u>56</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles M. Weber</u> M.D.				ADDRESS (Street, city or town, state) <u>Wheaton City Md</u>			
PHYSICIAN'S NAME (Type) <u>Charles M Weber</u>				DATE SIGNED <u>Oct 4, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King Solomon Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Clifton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Deaf Funeral Home 4812 N. Ave Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>10/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Teller</u>	

BUREAU V. S.

9561 51 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 214

10480

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10707 St. Marguerite Way</u>				d. STREET ADDRESS <u>10707 St. Marguerite Way</u>			
3. NAME OF DECEASED (Type or print) <u>Felix Klaber</u>				4. DATE OF DEATH <u>Oct. 15</u> 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 21, 1887</u>	
				9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
13. FATHER'S NAME <u>Louis Klaber</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Caroline Hirsch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Bodansky, 10707 St. Marguerite Way</u> Address <u>Nephew</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion, Myocardial Infarct 2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 13, 1956</u> , to <u>Oct 15, 1956</u> , that I last saw the deceased alive on <u>Oct 15, 1956</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.				ADDRESS (Street, city or town, state) <u>11301 Georgia Ave Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>John J. Curry</u>				DATE SIGNED <u>10/15/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		22d. LOCATION (City, town, or county) (State) <u>New York Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Bodansky & Ans, 3501 14th St. N.W.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>10/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10456

10481

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 831 GIST AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY SUE PARKER LEISSLER				4. DATE OF DEATH Month Day Year OCTOBER 7 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 16, 1893	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING CLERK (retired)			10b. KIND OF BUSINESS OR INDUSTRY ENGRAVING		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. D.		
13. FATHER'S NAME WILLIAM A. PARKER			14. MOTHER'S MAIDEN NAME MATTIE HAMILTON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-01-4917		17. INFORMANT Address MRS. ANNA M. BRADY, 831 GIST AVE., SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MITRAL INSUFFICIENCY DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE (c) CORONARY HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1948 , 19 OCT. , 19 56 , that I last saw the deceased alive on 7 OCT. , 19 56 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9013 FLOWER AVE SILVER SPRING, MD. DATE SIGNED 10/7/56							
ACTUAL SIGNATURE L. B. SNOW		M.D. L. B. SNOW					
PHYSICIAN'S NAME (Type) L. B. SNOW							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 11, 1956	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Werner E. Pumphrey			ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 10/9/56	24b. REGISTRAR'S SIGNATURE James Little	

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521-522

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BUREAU V.

9561 51 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10482
CERTIFICATE OF DEATH

10457

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>700 Forest Glen Road</u>		d. STREET ADDRESS <u>700 Forest Glen Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Hiram</u> Middle <u>Lewis</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1878</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Self Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Frances A. Mazingo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ada Lewis-Wife</u>		Address <u>Mrs. Orville S. Kennedy-700 Forest Glen Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon (transverse colon)</u> <u>153 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>Oct 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 29</u> , 19 <u>56</u> , and that death occurred at <u>2-2</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colesville Road</u> DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>Dr. John N. Andrews, M.D.</u> <u>9601 Colesville Road S.S., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rainswood, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., SE DC3</u>			
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Frances Patter</u>	

CERTIFICATE OF DEATH

10-25

NAME OF DECEASED [Faint text]		DATE OF DEATH [Faint text]	
AGE [Faint text]		SEX [Faint text]	
RACE [Faint text]		MARRIAGE [Faint text]	
EDUCATION [Faint text]		OCCUPATION [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
DATE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PREVIOUS ILLNESS [Faint text]		TREATMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF DEATH REGISTRAR [Faint text]	
DATE [Faint text]		DATE [Faint text]	
PLACE [Faint text]		PLACE [Faint text]	
COUNTY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		STATE [Faint text]	

RECEIVED
OCT 31 1956
BUREAU V. S.

10483

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4703 W. Virginia Ave</u>		STREET ADDRESS (If rural give location) <u>4703 W. Virginia Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rudolf</u> <u>Lieberts</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 26</u> <u>19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 10, 1876</u>
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Fruits & Wholesaler - Veg.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Wholesaler</u>	11. BIRTHPLACE (State or foreign country): <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>David Lieberts</u>	
14. MOTHER'S MAIDEN NAME: <u>Caroline Wallerstein</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Daughter-Miss Hermine Lieberts-Item 2</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>carcinoma of stomach</u>			<u>6 months</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Aug 1, 1956</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Generalized carcinomatosis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>June 1, 1956</u> to <u>Oct. 26, 1956</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>56</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Dr. J. H. Haines</u>		ADDRESS <u>6450 Wisconsin Ave. Bethesda, Md.</u>	
DATE SIGNED <u>10/26/56</u>		M. D. <u>10/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>10/26/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-27-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 31 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10484

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mongtomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 6 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3604 Little Dale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle OLIVIA Last LILLEY		4. DATE OF DEATH Month October Day 13 , Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1888
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 7 Days 9 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Plymouth, N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Taylor Walker Davis	
14. MOTHER'S MAIDEN NAME Lillian Ayers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Son Harold R. Lilley Address 3604 Little Dale Rd. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Vasculitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 hrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March, 19 53 to Oct 13, 19 56 , that I last saw the deceased alive on Oct 13, 19 56 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1711 R. I Ave NW Wash 6, D.C. DATE SIGNED 			
ACTUAL SIGNATURE James J. Feffer		M.D. 	
PHYSICIAN'S NAME (Type) James J. Feffer		Wash 6, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 10-14-56	22b. DATE THEREOF 10-14-56	22c. NAME OF CEMETERY OR CREMATORY Windley Cemetery	22d. LOCATION (City, town, or county) (State) Washington County, N. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 10-15-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

BUREAU V.

100 18 1956

RECEIVED

10485

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Moreland Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eloise</u> First <u>K</u> Middle <u>Linkins</u> Last				4. DATE OF DEATH <u>10-14-1956</u> Month <u>10</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-21-80</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. Henry Kaiser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>William J. Biggins, Jr.</u> Address <u>3925 W St. N.W.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, Metastatic, Liver, Cerebral</u> 157X DUE TO <u>Adenocarcinoma, Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year <u>1956</u> Hour a. m. <u>10-14</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>Washington, D.C.</u> (County) <u>—</u> (State) <u>—</u>				21. I certify that I attended the deceased from <u>Aug 15, 1956</u> to <u>Oct 15, 1956</u> that I last saw the deceased alive on <u>10-14, 1956</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard H. Strine</u> M.D. <u>900-17th St. N.W. Wash. D.C.</u>				DATE SIGNED <u>10-17-56</u>			
PHYSICIAN'S NAME (Type) <u>Howard H. Strine</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
22b. DATE THEREOF <u>10/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) <u>—</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u> ADDRESS <u>2901 14th St. N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>—</u>				24b. REGISTRAR'S SIGNATURE <u>Bernice M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 18 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10486
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Mar Park		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5204 Nahant Street		d. STREET ADDRESS 5204 Nahant Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin Middle LUCAS Last LUCAS		4. DATE OF DEATH Month October Day 5 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1905
9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months 4 Days 23	
IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Inspector		10b. KIND OF BUSINESS OR INDUSTRY State of Virginia	
11. BIRTHPLACE (State or foreign country) Czecho-Slovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Lucak		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) Korean		16. SOCIAL SECURITY NO. 204-34-1958	
17. INFORMANT Mary E. Lucas-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 356.1 Amyotrophic Lateral Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 11 mo. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Arrival - medical examiner notified		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Need on		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 5, 1956 to October 5, 1956 that I last saw the deceased alive on October 5, 1956 , and that death occurred at 7:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Virginia P. Beelar M.D.			
PHYSICIAN'S NAME (Type) Virginia P. Beelar, M.D.		5715 Massachusetts Ave. Glen Mar Pk. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-9-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 10-8-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

CERTIFICATE OF DEATH

Name of Deceased NORRIS, MARY		Sex Female		Age 31		Date of Birth May 12, 1903		Place of Birth Czechoslovakia		Country of Birth Czechoslovakia	
Residence 8304 Nathan Street		City Baltimore		State Maryland		County Baltimore		Zip 21204		Date of Death May 12, 1934	
Cause of Death Glenoid Prolapse		Immediate Cause Glenoid Prolapse		Intermediate Cause Glenoid Prolapse		Underlying Cause Glenoid Prolapse		Manner of Death Natural		Place of Death Home	
Physician Dr. Brochart		Hospital None		Nurse None		Funeral Home None		Burial Place None		Date of Burial None	
Signature of Physician Dr. Brochart		Signature of Registrar None		Signature of Coroner None		Signature of Medical Examiner None		Signature of Pathologist None		Signature of Toxicologist None	

Dr. Brochart notified and approved removal

RECEIVED
OCT 10 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10487 CERTIFICATE OF DEATH

10462

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9913 Tenbrook Drive		d. STREET ADDRESS 1868 Columbia Road, N.W. Apt 505	
3. NAME OF DECEASED (Type or print) First Sussie Middle Gertrude Last Mangum		4. DATE OF DEATH Month 10/22/56 Day Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Arthur B. Allen		14. MOTHER'S MAIDEN NAME Nettie Viola Leonard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		17. INFORMANT Clarence S. Allen, Address Ashton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hour
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 56 , to OCT 22 , 19 56 , that I last saw the deceased alive on October 22 , 19 56 , and that death occurred at 4:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Morris H. Rosenberg M.D. 2025 Eye St NW.		PHYSICIAN'S NAME (Type) MORRIS H. ROSENBERG.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10/25/56	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 10/24/56	24b. REGISTRAR'S SIGNATURE Frances Potter

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488

CERTIFICATE OF DEATH

10463

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County Gneral Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Martha Middle Selberta Last Marsell				4. DATE OF DEATH Month October Day 20 Year 19 56			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/90	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henson Taylor				14. MOTHER'S MAIDEN NAME Tony Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident (Cerebral hemorrhage) DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/19 , 19 56 , to 10/20 , 19 56 , that I last saw the deceased alive on 10/20 , 19 56 , and that death occurred at 11:10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg Md. DATE SIGNED ACTUAL SIGNATURE Lucius J. Leal M.D. 108 N. Frederick Ave. PHYSICIAN'S NAME (Type) L. I. Leal, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/23/56		22c. NAME OF CEMETERY OR CREMATORY Emory Grove	
22d. LOCATION (City, town, or county) (State) Gaithersburg Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md		24a. REC'D BY REGISTRAR DATE 10-24-56	
24b. REGISTRAR'S SIGNATURE Gertrude B Lawler							

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BUREAU A. S.

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10/10/10

10414 10464 Reg. Dist. No. 223 10414 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
c. LENGTH OF STAY IN 1b <u>15 days</u>				d. STREET ADDRESS <u>1349-A St. N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp. Takoma Park, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Dorothea</u> Last <u>Matthaei</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Henry Russel</u>				14. MOTHER'S MAIDEN NAME <u>Julia Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Wash. San. & Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> (c) <u>Carcinoma of uterus or ovary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1-2 yrs</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct 7, 1956</u> to <u>Oct 24, 1956</u> that I last saw the deceased alive on <u>Oct 24, 1956</u> , and that death occurred at <u>1:58 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u> DATE SIGNED <u>Dr. Raymond O. West</u>							
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D. <u>7600 Carroll Ave., Takoma Park, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Raymond O. West, M. D. 7600 Carroll Ave., Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	
22d. LOCATION (City, town, or county) <u>Smithland</u>				(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee Sons Co 300-4-7678</u>				ADDRESS <u>300-4-7678</u>		24a. REC'D BY REGISTRAR <u>10/27/56</u>	
24b. REGISTRAR'S SIGNATURE <u>John D. Dodel</u>				DATE <u>10/27/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 09 09

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10415

CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2726 30th Street NE</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Katherine</u> Last <u>McCalmont</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 12, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Schart</u>				14. MOTHER'S MAIDEN NAME <u>Anna Billingsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>McGerald C. McCalmont</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder with metastases</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>about 6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept 56</u> to <u>Oct 4 56</u> , that I last saw the deceased alive on <u>Oct 3, 56</u> , and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>130V 18th St. NW.</u> DATE SIGNED <u>10/4/56</u>							
ACTUAL SIGNATURE <u>Jack J. Rheingold</u> M.D.				PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington, Va.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u> ADDRESS <u>3200 R.I. Ave.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
MARRIED		JULY 1, 1963		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		PILGRIM	
EDUCATION		SCHOOLING		RELIGION		SPECIAL OCCASION		PREVIOUS ILLNESS		HISTORY OF DRUGS	
HIGH SCHOOL		12		METHODIST		NONE		NONE		NONE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAMES EARL RAY		LUCILLE RAY		PILGRIM		HOUSEWIFE		1908		1912	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
MOBILE, ALABAMA		MOBILE, ALABAMA		NONE		NONE		NONE		NONE	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
MARRIED		MARRIED		NATURAL		NATURAL		PILGRIM		HOUSEWIFE	
FATHER'S SCHOOLING		MOTHER'S SCHOOLING		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S SPECIAL OCCASION		MOTHER'S SPECIAL OCCASION	
12		12		METHODIST		METHODIST		NONE		NONE	
FATHER'S PREVIOUS ILLNESS		MOTHER'S PREVIOUS ILLNESS		FATHER'S HISTORY OF DRUGS		MOTHER'S HISTORY OF DRUGS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
NONE		NONE		NATURAL		NATURAL		PILGRIM		HOUSEWIFE	
FATHER'S SCHOOLING		MOTHER'S SCHOOLING		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S SPECIAL OCCASION		MOTHER'S SPECIAL OCCASION	
12		12		METHODIST		METHODIST		NONE		NONE	
FATHER'S PREVIOUS ILLNESS		MOTHER'S PREVIOUS ILLNESS		FATHER'S HISTORY OF DRUGS		MOTHER'S HISTORY OF DRUGS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
NONE		NONE		NONE		NONE		NONE		NONE	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
NONE		NONE		NATURAL		NATURAL		PILGRIM		HOUSEWIFE	

BUREAU V. 3

OCT 9 1966

RECEIVED

10489

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 12 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805 KING STREET				d. STREET ADDRESS 805 KING STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last MCCOLLAM				4. DATE OF DEATH Month OCTOBER Day 11 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 30, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER				10b. KIND OF BUSINESS OR INDUSTRY CONTRACTORS		11. BIRTHPLACE (State or foreign country) BLADENSBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD F. MCCOLLAM				14. MOTHER'S MAIDEN NAME EMMA CHANEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578-01-9184		17. INFORMANT Address Mrs. Mary B. Carr, 805 King St., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER							INTERVAL BETWEEN ONSET AND DEATH 24 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , 19 56 , to 11 Oct , 19 56 , that I last saw the deceased alive on 11 Oct , 19 56 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L.B. SNOW				ADDRESS (Street, city or town, state) 9013 FLOWER AVE SILVER SPRING, MD.			
PHYSICIAN'S NAME (Type) L. B. SNOW				DATE SIGNED 10/12/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 10/19/56	
				24b. REGISTRAR'S SIGNATURE Francis Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-2-5

BUREAU V. S.

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10467

10490

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annandale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>5013 Bristow Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>MC</u> Last <u>DONOUGH</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Oct. 1956</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert C. Mc Donough</u>		14. MOTHER'S MAIDEN NAME <u>Juliette Marie Schonekas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father) Robert C. Mc Donough (Same As #2)</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>Fetal atelectasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>19 Oct.</u> , 19 <u>56</u> , to <u>19 Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19 Oct.</u> , 19 <u>56</u> , and that death occurred at <u>1:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John H. Mazur</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>10-20-56</u> PHYSICIAN'S NAME (Type) <u>John H. Mazur, LT MC USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>10-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>23 Oct. 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>10-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Canally</u>	

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$$\left(\begin{array}{c} \vdots \\ \vdots \\ \vdots \end{array} \right)$$

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. + Hosp.</u>				d. STREET ADDRESS <u>6817 Georgia Ave NW</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNETTE</u> Middle <u>Mendelsohn</u> Last <u></u>				4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-98</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Louis Walshy</u>				14. MOTHER'S MAIDEN NAME <u>Esther Sipp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>517-44-9508</u>		17. INFORMANT <u>Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 4443X DUE TO <u>Hypertensive Heart & Sclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cardio Vascular Disease</u> (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>may 4 years</u> <u>about 16 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>10/6</u> , 19 <u>56</u> , to <u>10/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>56</u> , and that death occurred at <u>6:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>		M.D. <u>7733 Alaska Ave NW</u>		ADDRESS (Street, city or town, state) <u>Washington, D.C.</u>		DATE SIGNED <u>10/11/56</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-14-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		22d. LOCATION (City, town, or county) <u>Baltimore md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Caldering Funeral Home</u>		ADDRESS <u>4217-95th Ave NW</u>		24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

OCT 17 1956

RECEIVED

10491

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>11 YEARS</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8808 READING ROAD</u>				d. STREET ADDRESS <u>8808 READING ROAD</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALEXANDRA</u> Middle <u>MILKIE</u> Last <u>MILKIE</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 FEB ? 1966</u>	
				9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LEBANON</u>	
13. FATHER'S NAME <u>ABRAHAM MAERIGE</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE JETTA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or date of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mr. Michael Milkie-Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X Congestive Heart Failure, acute</u> DUE TO <u>Cerebral Hemorrhage with Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c) <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 1957</u> to <u>Oct 31, 1956</u> , that I last saw the deceased alive on <u>Oct. 31, 1956</u> , and that death occurred at <u>1030 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.B. Snow</u>				DATE SIGNED <u>11/1/56</u>			
PHYSICIAN'S NAME (Type) <u>L.B. SNOW</u>				ADDRESS (Street, city or town, state) <u>9013 Flower Ave Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Collier</u>	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10492

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5803 Johnson Court		d. STREET ADDRESS 5803 Johnson Court	
3. NAME OF DECEASED (Type or print) First Wilson Middle Noble Last MILLER		4. DATE OF DEATH Month October Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1880
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Plate printer		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engrav.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilson Porter Miller		14. MOTHER'S MAIDEN NAME Mary F. Darby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Frances Daly-Same Item #2-daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis General DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs. yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APR. 1952 to OCT. 10, 1956 that I last saw the deceased alive on OCT. 10, 1956 and that death occurred at 9:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave. Bethesda Md DATE SIGNED 10/10/56			
ACTUAL SIGNATURE Leo M. Curtis		PHYSICIAN'S NAME (Type) Leo M. Curtis, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/1956	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR 10-11-56	
24b. REGISTRAR'S SIGNATURE Bessie S. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JOHN J. JOHNSON		45		M		W		1911		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
OCTOBER 23, 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. J. JOHNSON	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	
				JOHN J. JOHNSON							

BUREAU V. 8

OCT 15 1956

RECEIVED

DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
OCTOBER 23, 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. J. JOHNSON	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

10493

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 7 Ardmore Court	
3. NAME OF DECEASED (Type or print) First Charles Middle Carroll Last Morgan, Jr.		4. DATE OF DEATH Month October Day 23 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10b. KIND OF BUSINESS OR INDUSTRY Security & Trusts	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles C. Morgan, Sr.		14. MOTHER'S MAIDEN NAME Adelaide L. Tuttle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give year or dates of service) WW II		16. SOCIAL SECURITY NO. 577-40-4922	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190x malignant melanoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) diffusely metastatic DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 28, 1956 , to October 23, 1956 , that I last saw the deceased alive on October 23, 1956 , and that death occurred at 12:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David G. Nathan, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center National Institutes of Health Bethesda 14, Maryland 10/23/56	
PHYSICIAN'S NAME (Type) David G. Nathan, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/25/56	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Grawley Sons		1756 Pennsylvania Ave Washington, D.C.	
24a. REC'D BY REGISTRAR DATE 10-25-56		24b. REGISTRAR'S SIGNATURE Beattie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
John J. Smith		October 25, 1956		The Medical Center, Baltimore, Md.	
Age		Sex		Race	
65		Male		White	
Marital Status		Occupation		Cause of Death	
Married		Engineer		Heart Disease	
Date of Birth		Place of Birth		Signature of Physician	
October 25, 1956		Baltimore, Md.		[Signature]	
Signature of Registrar		Signature of Medical Officer		Signature of Health Officer	
[Signature]		[Signature]		[Signature]	
Date of Registration		Place of Registration		Signature of Registrar	
October 25, 1956		Baltimore, Md.		[Signature]	

BUREAU V. S.

OCT 30 1956

RECEIVED

10/30/56
1756 Pennsylvania Ave NW
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10472

Reg. Dist. No. 223

10417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>14</u> days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7710 Blair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Coy</u> Middle <u>Thomas</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
13. FATHER'S NAME <u>John Thomas Morris</u>				14. MOTHER'S MAIDEN NAME <u>Maud HOBGOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary hemorrhage</u> <u>900.0</u> DUE TO <u>Cerebral laceration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down basement steps at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:00</u> a. m. <u>10/13</u> <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>				22b. DATE THEREOF <u>10/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WENDELL CEMETERY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Hickner & Son</u>				24a. REC'D BY REGISTRAR <u>Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Addy</u>	
25. LOCATION (City, town, or county) <u>WENDELL, N.C.</u>				26. DATE <u>10/29/1956</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF TEXAS
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF MEDICAL EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
OCT 30 1956
BUREAU V. S.

10494

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>1711 MAYHEW DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>Elma Jane Moss</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE RAKER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH McVOY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Wm. Andrew Fagan, 4303 Elderon Ave.</u>		Address <u>Baltimore, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Cerebral Ar. Sclerosis</u> (c) <u>Arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis - one day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1953</u> , <u>1955</u> , to <u>6 Oct</u> , <u>1956</u> , that I last saw the deceased alive on <u>6 Oct</u> , <u>1956</u> , and that death occurred at <u>4 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.		ADDRESS (Street, city or town, state) <u>11134 Georgia Ave SE, 2060156</u>	
PHYSICIAN'S NAME (Type) <u>Merton L. White</u>		DATE SIGNED <u>6 Oct 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 9, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>10/9/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James M. [illegible]</i>		DATE OF DEATH <i>10-10-1956</i>	
AGE <i>68</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RESIDENCE <i>1234 [illegible] St. Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF BIRTH <i>10-10-1888</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
DATE OF DEATH <i>10-10-1956</i>		PLACE OF DEATH <i>Home</i>	
TIME OF DEATH <i>10:00 AM</i>		TEMPERATURE <i>Normal</i>	
PULSE <i>Normal</i>		BLOOD PRESSURE <i>Normal</i>	
RESPIRATION <i>Normal</i>		NEUROLOGICAL <i>Normal</i>	
GROSS EXAMINATION <i>Normal</i>		HISTOPATHOLOGY <i>Normal</i>	
MICROSCOPIC <i>Normal</i>		RADIOLOGY <i>Normal</i>	
LABORATORY <i>Normal</i>		OTHER <i>Normal</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		DATE <i>10-10-1956</i>	
SIGNATURE OF REGISTRAR <i>[Signature]</i>		DATE <i>10-10-1956</i>	

BUREAU V. E.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film C206 11-8-56 et

CERTIFICATE OF DEATH

10474

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Daniel Mudd</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Daniel H. Mudd</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Madeline M. Killebrew - Stepsister</u>				Address <u>5113 Spenable Rd. Sumner, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>longestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarction, posterior</u> DUE TO (c) <u>coronary arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>25 Oct., 1956</u> , to <u>27 Oct., 1956</u> , that I last saw the deceased alive on <u>26 Oct., 1956</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sevuch T. Kimble</u>				ADDRESS (Street, city or town, state) <u>929 Pershing Drive, Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>SEVUCH T. KIMBLE</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cem.</u>	
22d. LOCATION (City, town, or county) <u>Lanham, Md.</u>				(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Davidson</u>				ADDRESS <u>Lanham, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>				DATE <u>10-31-56</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

City

Place of Death

Age

Sex

Color

Occupation

Marital Status

Education

Religion

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Date of Death

Place of Death

Time of Death

Cause of Death

Manner of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Chemist

Signature of Microscopist

Signature of Radiologist

Signature of Anatomist

Signature of Histologist

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

BUREAU V. 1

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10496 CERTIFICATE OF DEATH

10475
Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9217 KINGSBURY DRIVE				d. STREET ADDRESS 9217 KINGSBURY DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle GUY Last NEEL				4. DATE OF DEATH Month OCT. Day 11 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/26/95	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER				10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (State or foreign country) NEELSVILLE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES BARNES NEEL				14. MOTHER'S MAIDEN NAME KATHERINE HOYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #1				16. SOCIAL SECURITY NO. 218-20-1742			
17. INFORMANT Mrs. Lucille H. Neel, 9217 Kingsbury Dr. Silver Spring, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary artery insufficiency 420.1 DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis coronary arteries. INTERVAL BETWEEN ONSET AND DEATH 15 minutes 22 months Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 48 , to October 11 , 19 56 , that I last saw the deceased alive on October 6 , 19 56 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8237 George Ave Silver Spring Md DATE SIGNED 10/11/56 ACTUAL SIGNATURE Aaron H. Traum M.D. PHYSICIAN'S NAME (Type) AARON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/13/56		22c. NAME OF CEMETERY OR CREMATORY NEELSVILLE CEMETERY	
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND							
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MARYLAND				24a. REC'D BY REGISTRAR DATE 10/19/56		24b. REGISTRAR'S SIGNATURE James C. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10472

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]	
SIGNATURE OF JUDGE [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF [Faint text] [Faint text]	

BUREAU V. 2

OCT 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10497

CERTIFICATE OF DEATH

10476

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>				d. STREET ADDRESS <u>2817 Cathedral Ave., N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Nicholson</u> Last <u>NEWTON</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Reverdy Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Ada Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Husband) Wallace S. Newton (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageal varices</u> DUE TO (c) <u>Cirrhosis of the liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 mos</u> <u>2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>30 Sept.</u> , 19 <u>56</u> , to <u>18 Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 Oct.</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J.T. Horgan</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 10-19-56</u> PHYSICIAN'S NAME (Type) <u>J.T. HORGAN, LT MC USN</u> <u>U.S. Naval Hospital, Bethesda, Md. 10-19-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u> R.A. Humphrey Funeral Home, 7557 Wisconsin Ave.				24a. REC'D BY REGISTRAR <u>10-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>May E. Parrelly</u>	

BUREAU V. 8

1956 22 OCT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10477

CERTIFICATE OF DEATH

Reg. Dist. No.

216

10498

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4863 Battery Lane		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
4. NAME OF DECEASED (Type or print) First Middle Last Katherine C. O'Brien		4. DATE OF DEATH Month Day Year Oct. 30, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Michael A. Carmody		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry O. O'Brien		Address 4863 Battery Lane Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 pulmonary edema DUE TO (b) congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerotic coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3-4 years 4-10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) auricular fibrillation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 3:20 p.m. 10/30/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28 , 19 56 , to 10/30 , 19 56 , that I last saw the deceased alive on 10/28 , 19 56 , and that death occurred at 3:20 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles J. Savarese, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 4861 A Battery Lane, Bethesda, Md. 10-30-56	
PHYSICIAN'S NAME (Type) Charles J. Savarese, Jr.		ADDRESS 4861A Battery Lane, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 10-30-56		22b. DATE THEREOF 10-30-56	
22c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		22d. LOCATION (City, town, or county) (State) Allegheny Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 10-2-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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BUREAU V. S.

104-2, 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 105 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
National Institutes of Health, Bethesda, Md.				d. STREET ADDRESS R.F.D.#4			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Mary Last Otto				4. DATE OF DEATH Month October Day 29 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 February 1914	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 8 Days 23 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Clerk				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME John Holyst				14. MOTHER'S MAIDEN NAME Mary Lesniak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center	
				National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma of Tongue 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) For Lung, Heart, Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
				20f. (City or town) 		(County) (State) 	
21. I certify that I attended the deceased from July 16, 1956 , to October 29, 1956 , that I last saw the deceased alive on October 29, 1956 , and that death occurred at 8:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/30/56							
ACTUAL SIGNATURE Thomas Waldman				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Thomas Waldman, M. D.				National Institutes of Health, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pennington				ADDRESS 1557 Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 10-31-56	
				24b. REGISTRAR'S SIGNATURE Bessie W. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		11/2/1966		Baltimore, Md.	
Cause of Death		Manner of Death		Occupation		Residence		Hospital	
Heart Disease		Natural		Teacher		1234 Main St.		St. Mary's Hospital	
Physician		Medical Examiner		Burial Place		Date of Burial		Burial Place	
Dr. J. Smith		Dr. J. Smith		St. Mary's Cemetery		11/5/1966		St. Mary's Cemetery	

BUREAU V. 2

NOV 2 1966

RECEIVED

Date of Report		Reported by		Signature		Title	
11/2/1966		John Doe		[Signature]		Physician	

10500

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5015 Del Ray Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Eleanor PARENT</u>				4. DATE OF DEATH Month Day Year <u>10-26 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-30-94</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6 25</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Barton</u>				14. MOTHER'S MAIDEN NAME <u>MARY Inscow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS. Anne Thaine</u> Address <u>5015 Del Ray Ave. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Be: lat broncho pneumonia</u> DUE TO (b) <u>Uterine Carcinoma - wide spread metastases</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>174X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days 6 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Agranulocytosis</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-23</u> , 1956, to <u>10-26</u> , 1956, that I last saw the deceased alive on <u>10-25</u> , 1956, and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Tickten</u> M.D.				ADDRESS (Street, city or town, state) <u>2250 Wash. Ave. Silver Spring, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Howard E. Tickten</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arling5on National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 10-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 3

NOV 1 1956

RECEIVED

Thirteenth

Thirteenth

1-30-5

1956

COPIES TO: Bureau of Health Statistics, etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
10501
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10480

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>510 Longwood Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>Parker</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 26, 1936</u>
9. AGE (In years lost birthday) yrs. <u>15</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elwood Davis Parker</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Irene Castle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address <u>(same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Bilateral, L.L.</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyaline Membrane Disease (?)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours + 15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 26, 1956</u> to <u>Oct 27, 1956</u> , that I last saw the deceased alive on <u>Oct 27, 1956</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Jagers</u>		ADDRESS (Street, city or town, state) <u>5707 WISCONSIN AVE</u>	
PHYSICIAN'S NAME (Type) <u>FRANK JAGGERS</u>		DATE SIGNED <u>10/27/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>10-30-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10429
CERTIFICATE OF DEATH

10481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	c. LENGTH OF STAY IN 1b <u>8 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Monroe St</u>		d. STREET ADDRESS <u>213 Monroe St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Erna</u> Middle <u>Wagner</u> Last <u>Parrish</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1936</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8-1927</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frankford, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Heinrick Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Maria Werner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>577-42-3097</u>	
17. INFORMANT <u>Harry D. Parrish</u> Address <u>213 Monroe St. Rockville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsions</u> <u>322.2</u> DUE TO <u>alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>mental</u> (c) <u>mentally - 4-5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct - 13 - 1936</u> , to <u>Oct - 16 - 1936</u> , that I last saw the deceased alive on <u>Oct - 13 - 1936</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Md</u> DATE SIGNED <u>William C. Miller</u>			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D. <u>Gaithersburg, Md</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		<u>GAITHERSBURG, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-19-1936</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>Lawrence Kratoch</u> 24b. REGISTRAR'S SIGNATURE <u>Lawrence Kratoch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		OTHER	
WHITE		WHITE		METHODIST		MARRIED		SINGLE		WIDOWED		DIVORCED		OTHER	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOSPITAL		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
OCT 12 1968		10:00 PM		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 8

OCT 22 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10502
CERTIFICATE OF DEATH

10482

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY SS.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON NURSING HOME				d. STREET ADDRESS 3000 MC COMAS ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle PAUL Last PAUL		4. DATE OF DEATH Month 10 Day 2 Year 1956		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 21, 1874		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 10 Days 2 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER RET.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT EMILE PAUL		Address 8411 HARTFORD AVE. SS. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILITY DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 56 , to October , 19 56 , that I last saw the deceased alive on Oct 1 , 19 56 , and that death occurred at 11:55 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard H Fitzgerald		M.D. 9620 Old Bladensburg Rd		ADDRESS (Street, city or town, state) W. HYATTSVILLE MD		DATE SIGNED 10-3-56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON		22d. LOCATION (City, town, or county) (State) W. HYATTSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				ADDRESS 3501-14 St NW		24a. REC'D BY REGISTRAR DATE 10-6-56	
				24b. REGISTRAR'S SIGNATURE Bessie M Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED Mrs. Mary Ann Jones		SEX Female	
AGE 65		DATE OF BIRTH Jan 15 1875	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Baltimore, Md.	
OCCUPATION None		CAUSE OF DEATH Senility	
MEDICAL HISTORY None		PRESENT ILLNESS None	
DATE OF DEATH Oct 3 1956		TIME OF DEATH 11:00 AM	
SIGNATURE OF PHYSICIAN J. H. Jones		SIGNATURE OF REGISTRAR J. H. Jones	

BUREAU V. 1

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10418

CERTIFICATE OF DEATH

10483

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <u>Lakoma Park</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Rest Home</u> <u>517 Albany Ave.</u>				d. STREET ADDRESS <u>3707 Spring Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen L. Perry</u> First Middle Last				4. DATE OF DEATH October 5, 1956 Month Day Year		19	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/89</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Batavia, New York</u>	
13. FATHER'S NAME <u>M. Considine</u>				14. MOTHER'S MAIDEN NAME <u>---O'Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records of rest Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C.V. disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1-2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>0</u> <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>10/3/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/4/</u> , 19 <u>56</u> , and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 Underwood Dr NW</u> DATE SIGNED ACTUAL SIGNATURE <u>Chas H. Wilson</u> M.D. <u>Wash. D.C.</u> PHYSICIAN'S NAME (Type) <u>Chas H. Wilson</u> <u>Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Pines Co. 2901-14 St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>10/7/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>	

BUREAU V.

BUREAU A. S.

OCT 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10484
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 215
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Virginia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 16 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Virginia Beach 83x 3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland					d. STREET ADDRESS 115 53rd St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Richard		Middle William		Last PHILLIPS		4. DATE OF DEATH Month October Day 2 Year 1956		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1916		9. AGE (In years last birthday) 39 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Florida			12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William Phillips					14. MOTHER'S MAIDEN NAME Frances J. Goodman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) 5 cc. laceration of right forehead (fell from bed in hospital)								INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 cc. laceration of right forehead (fell from bed in hospital)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. (neither)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year 09:40 a.m. 10-2-1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital		20f. (City or town) Bethesda, Montgomery, Md.		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 10-8-56 b		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey R.A. Humphrey Funeral Home					ADDRESS Bethesda, Md. 7557 Wisc. Ave.,		24a. REC'D BY REGISTRAR DATE 10-2-56		24b. REGISTRAR'S SIGNATURE May L. Casella	

1956 5 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10504
 CERTIFICATE OF DEATH

10485

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY aa			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O. A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Nat'l Naval Med. Center				d. STREET ADDRESS 1023 Madison Ave.			
3. NAME OF DECEASED (Type or print) MARION VINCENT PHIPPS				4. DATE OF DEATH Month OCT. Day 26 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 21, 1938	
9. AGE (In years last birthday) yrs. 18		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN	
10b. KIND OF BUSINESS OR INDUSTRY BOAT YARD		11. BIRTHPLACE (State or foreign country) aa Co Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank V. Phipps				14. MOTHER'S MAIDEN NAME Dorothy V. Phipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank V. Phipps		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Monocytic Leukemia 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10-13-1956 to 10-26-1956 , that I last saw the deceased alive on 10-26-1956 , and that death occurred at 3:30P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Martin				ADDRESS (Street, city or town, state) M.D. 185 Prince George Annapolis Md			
PHYSICIAN'S NAME (Type) JAMES R. MARTIN				DATE SIGNED 10/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF OCT 29-56		22c. NAME OF CEMETERY OR CREMATORY HILLCREST MEMORIAL		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Son Annapolis Md		24a. REC'D BY REGISTRAR DATE 10/29/56	
				24b. REGISTRAR'S SIGNATURE V. D. [Signature]			

CERTIFICATE OF DEATH

10004

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS DEATHS	
SPECIAL INQUIRY		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		OFFICE OF REGISTRATION	

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10505 CERTIFICATE OF DEATH

10486

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS 5510 Lincoln			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Etta Middle Poole Last Poole				4. DATE OF DEATH Month Oct Day 28 Year 1956			
5. SEX Fe	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 1 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawson Poole				14. MOTHER'S MAIDEN NAME Elizabeth Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 5510 Lincoln St. Mrs. Ursula Russell, Sister Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of descending colon DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 days 18 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cardio vascular Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 April, 1955 , to 28 Oct , 1956, that I last saw the deceased alive on 27 Oct , 1956, and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Georgetown Rd Bethesda Md. DATE SIGNED 							
ACTUAL SIGNATURE John G. Ball		M.D. 7936 Georgetown Rd Bethesda Md.					
PHYSICIAN'S NAME (Type) John G. Ball							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince Georges Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md		24a. REC'D BY REGISTRAR DATE 1-30-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10487

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5111 Edgemore Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>M</u> Last <u>Bornell</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael J. Laven Nave</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen J. Harbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Martha B. Lewis</u>		Address <u>Bethesda, Md. 5111 Edgemore Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Marked anemia</u> DUE TO (c) <u>Endometrial carcinoma</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Obesity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>6 wks.</u> <u>Undet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 25</u> , 19 <u>56</u> , to <u>Oct. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 25</u> , 19 <u>56</u> , and that death occurred at <u>12:56 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u>		ADDRESS (Street, city or town, state) <u>104 Chevy Chase Dr., Chevy Chase 15, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Geo. A. Gray, Jr.</u>		DATE SIGNED <u>10/26/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - 1st</u>	22b. DATE THEREOF <u>10-27-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Nicholasville Kentucky</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>10-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Basile M. Thompson</u>	

BUREAU V. S.

OCT 30 1956

RECEIVED

CERTIFICATE OF DEATH

10488
276

Reg. Dist. No.

10507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
		d. STREET ADDRESS <u>12 Oldham Road</u>	
3. NAME OF DECEASED (Type or print) <u>Amy</u> First <u>Kelly</u> Middle <u>Quisenberry</u> Last		4. DATE OF DEATH <u>Oct.</u> Month <u>1</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1885</u> yrs. <u>71</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR <u> </u> Months <u> </u> Days <u> </u> Hours <u> </u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Sniffin</u>		14. MOTHER'S MAIDEN NAME <u>Ella Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ethel A. Wills</u> Address <u>12 Oldham Rd. Silver Sp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarcts both lower lobes</u> DUE TO <u>180X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophied Ca. Rt. Kidney with</u> DUE TO <u>local massive recurrence of metastatic</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs</u> <u>2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1954</u> , to <u>10/1/56</u> , that I last saw the deceased alive on <u>10/1/56</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen D Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md</u> DATE SIGNED <u>10/1/56</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 3, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Compassionate</u>	22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>Wash D.C.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Jessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 7 1956

RECEIVED

10419

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>silver spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San & Hosp.</u>				d. STREET ADDRESS <u>110 St Lawrence Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arthur</u> Last <u>Randall</u>				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 1907</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bacteriologist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food & Drug</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Dc.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Rachel William Randall</u>			
14. MOTHER'S MAIDEN NAME <u>Blanche Phillips</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>578-16-9737</u>				17. INFORMANT <u>Mrs. M. Marie Randall, wife</u> Address <u>110 St. Lawrence Drive, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____, 19____, to <u>13 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>13 Oct</u> , 19 <u>56</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D. <u>9006 Glenville Rd</u> ADDRESS (Street, city or town, state) <u>Silver Spring Md</u> DATE SIGNED <u>13 Oct 56</u>				PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Humphrey</u> ADDRESS <u>34 Georgia Ave Spring</u>				24a. REC'D BY REGISTRAR <u>J. M. Dool</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 22 1956

RECEIVED

10430

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b <u>10 Yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1006 Crawford Dr.</u>				d. STREET ADDRESS <u>1006 Crawford Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>LEITH</u> Last <u>RAWLINGS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1869</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter Leith Rawlings</u> Address <u>1006 Crawford Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden left ventricular failure</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diastolic atherosclerosis (arteriosclerosis & calcification)</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 29, 1956</u> , to <u>Oct. 30, 1956</u> , that I last saw the deceased alive on <u>Oct. 29, 1956</u> , and that death occurred at <u>1 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. A. Linthicum</u> M.D.				ADDRESS (Street, city or town, state) <u>110 S. Wash. St., Rockville</u> DATE SIGNED <u>10/30/56</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM A. LINTHICUM</u>				ADDRESS <u>110 S. Washington St., Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>10-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Loudoun County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <input checked="" type="checkbox"/> <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 10-31-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1956	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JANUARY 10, 1891		BALTIMORE, MARYLAND	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
SPOUSE'S NAME		OCCUPATION	
JAMES H. HARRIS		RETIRED	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
PLACE OF DEATH		RESIDENT	
HOME		YES	
HOSPITAL		NO	
NATURAL		ACCIDENT	
YES		SUICIDE	
NO		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
JANUARY 10, 1956		JANUARY 10, 1956	

BUREAU V. 3

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10508
CERTIFICATE OF DEATH

10491

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 6905-MAPIE AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HELEN Middle M Last READ				4. DATE OF DEATH Month OCT. Day 2 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 30-1868 88 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. Francis Reeves				14. MOTHER'S MAIDEN NAME Helen M. Reeves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Son - Mr. E. H. Read				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left breast DUE TO (c) Metastases				INTERVAL BETWEEN ONSET AND DEATH 8 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 26, 1956 , to Oct 2, 1956 that I lost the deceased alive on Oct 2, 1956 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Casady M.D.				ADDRESS (Street, city or town, state) 5022 Reno Rd. N.W.			
DATE SIGNED Oct 2 '56							
PHYSICIAN'S NAME (Type) John W. Casady M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF OCT. 2, 1956		22c. NAME OF CEMETERY OR CREMATORY LEES CREMATORY		22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees - 300-4th ST. N.E. WASH. D.C.				ADDRESS		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Bessie Thompson							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is filled out with handwritten text, which is mostly illegible due to the quality of the scan. Some legible text includes "JAN 1956" and "BUREAU V. S.".

CHIEF CLERK
RECEIVED
OCT 4 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10492

Reg. Dist. No. 214

10509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2500 Seminary Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2500 Seminary Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First <u>Wayne</u> Middle <u>Rembert</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1956</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/1901</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>world bank</u>				11. BIRTHPLACE (State or foreign country) <u>Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest W. Rembert</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW #1</u>				16. SOCIAL SECURITY NO. <u>146-09-3088</u>				17. INFORMANT <u>Hazel Rembert (wife)</u> Address <u>Same as # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10/21/56</u>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>				22d. LOCATION (City, town, or county) <u>Arlington Co., Va.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>						ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Otter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10493

CERTIFICATE OF DEATH

Reg. Dist. No. 216

10510

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 202 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 431			
3. NAME OF DECEASED (Type or print) First Eula Middle Catherine Last Riggleman				4. DATE OF DEATH Month October Day 16 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1912	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 10 Days 20 Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY School for Boys	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Perry Riggleman			
14. MOTHER'S MAIDEN NAME Henrietta Lewis				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) brain tumor 2° to 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic malignant melanoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) 				20g. (City or town) (County) (State) 			
21. I certify that I attended the deceased from March 28, 19 56 , to October 16, 19 56 , that I last saw the deceased alive on October 16, 19 56 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Weissman M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 10/16/56							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORY Davis		22d. LOCATION (City, town, or county) (State) Tucker Co. West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR 10-18-56		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

RECEIVED

OCT 22 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10494

Reg. Dist. No. 216

10511

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 19 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3300 Rolling Rd.				d. STREET ADDRESS 3300 Rolling Rd.			
3. NAME OF DECEASED (Type or print) Marguerite Bimel Rightor First Middle Last				4. DATE OF DEATH Month Oct Day 29 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Bimel				14. MOTHER'S MAIDEN NAME Clara Bradly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chester Rightor(husband) Same # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince George Co., Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 10/29/56							
22a. BURIAL, CREMATION, or other disposition Cremation		22b. DATE THEREOF 10/30/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS		24a. REC'D BY REGISTRAR 10-81-56	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED ROBERT A. TUNNEY		AGE 35		SEX Male		RACE White		DATE OF DEATH Nov 2 1956	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION None		EDUCATION High School		MARRIAGE Married		SINGLE Never		DIVORCED Never	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		MORBID CAUSE None	
DATE OF EXAMINATION Nov 2 1956		TIME OF EXAMINATION 10:00 AM		PLACE OF EXAMINATION Home		BY J. H. Smith, M.D.		ASSISTED BY None	
SIGNATURE OF EXAMINER J. H. Smith, M.D.		SIGNATURE OF ASSISTANT None		SIGNATURE OF WITNESS None		SIGNATURE OF DECEASED None		SIGNATURE OF NEXT OF KIN None	
DATE OF SIGNATURE Nov 2 1956		TIME OF SIGNATURE 10:00 AM		PLACE OF SIGNATURE Home		BY J. H. Smith, M.D.		ASSISTED BY None	
SIGNATURE OF DECEASED None		SIGNATURE OF NEXT OF KIN None		SIGNATURE OF WITNESS None		SIGNATURE OF ASSISTANT None		SIGNATURE OF EXAMINER J. H. Smith, M.D.	
DATE OF SIGNATURE Nov 2 1956		TIME OF SIGNATURE 10:00 AM		PLACE OF SIGNATURE Home		BY J. H. Smith, M.D.		ASSISTED BY None	
SIGNATURE OF EXAMINER J. H. Smith, M.D.		SIGNATURE OF ASSISTANT None		SIGNATURE OF WITNESS None		SIGNATURE OF DECEASED None		SIGNATURE OF NEXT OF KIN None	
DATE OF SIGNATURE Nov 2 1956		TIME OF SIGNATURE 10:00 AM		PLACE OF SIGNATURE Home		BY J. H. Smith, M.D.		ASSISTED BY None	

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10495

10512

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Henrico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #1, Box 192			
3. NAME OF DECEASED (Type or print) First Clyde Middle Leland Last Robins				4. DATE OF DEATH Month October Day 5th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1904		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin R. Robins				14. MOTHER'S MAIDEN NAME Maggie Garthright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-22-1968		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcal Meningitis 134.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 29, 19 56 , to October 5, 19 56 , that I last saw the deceased alive on October 5, 19 56 , and that death occurred at 12:47 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard K. Merchant M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 10/6/56	
PHYSICIAN'S NAME (Type) Richard K. Merchant, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8 Oct 1956		22c. NAME OF CEMETERY OR CREMATORY Washington Memorial		22d. LOCATION (City, town, or county) (State) Henrico Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Woody HENRY W. WOODY				ADDRESS Richmond, Va.		24a. REC'D BY REGISTRAR OCT 8 1956	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

C. 1999.

2

2000

6205-52-000

BUREAU V. 8

1956 8 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
105'3
CERTIFICATE OF DEATH

10496

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2-5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3926 Washington St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATHERINE Middle M Last ROGERS				4. DATE OF DEATH Month Oct. Day 2 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1881	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 3 Days 22 Hours Min. 		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Charles Ostrander				14. MOTHER'S MAIDEN NAME Julia A. Broadwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Helen G. Ostrander-3504 Fairview Ave. Balt	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, essential DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-5 days Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 56 Hour a. m. p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) 				20g. (City or town) (County) (State) 			
21. I certify that I attended the deceased from 9-30 , 19 56 , to 10-2 , 19 56 , that I last saw the deceased alive on 10-2 , 19 56 , and that death occurred at 3:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11602 Georgia Ave. DATE SIGNED 10-2-56 ACTUAL SIGNATURE Morris Perry M.D. Silver Spring Md PHYSICIAN'S NAME (Type) Morris Perry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tr.				22b. DATE THEREOF 10-4-56		22c. NAME OF CEMETERY OR CREMATORY Esperance, N.Y.	
22d. LOCATION (City, town, or county) Esperance				(State) New York			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 10-2-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

RECEIVED

OCT 5 1956

BUREAU V. 3

10514

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: 5519 Sonoma Rd Bethesda Md				2. USUAL RESIDENCE (HOME) OF DECEASED: 5519 Sonoma Rd. Bethesda Md.			
COUNTY Montgomery		MARYLAND Md		STATE Md		COUNTY Montgomery	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)		RURAL and give nearest town)	
TOWN Bethesda		16 years		TOWN Bethesda			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5519 Sonoma Rd.				STREET ADDRESS (If rural give location) 5519 Sonoma Rd.			
3. NAME OF DECEASED: (First) Carrie (Middle) May (Last) (Wanamaker) Rowe				4. DATE (Month) (Day) (Year) OF DEATH: Oct 30 1956			
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: 27 Aug 1874	
				9. AGE last birthday: 82 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife				10B. KIND OF BUSINESS OR INDUSTRY: —		11. BIRTHPLACE (State or foreign country): Mt Carmel, Pa.	
13. FATHER'S NAME: Jacob Wanamaker				14. MOTHER'S MAIDEN NAME: Mary Elizabeth Rupp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Wme		17. INFORMANT'S ADDRESS: Corinne A. Rowe-daughter - Address Same	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
203X IMMEDIATE CAUSE (A) Multiple Myeloma		3 years
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive and arteriosclerotic heart disease	10 years
--	----------

19A. DATE OF OPERATION: Bone Marrow Jan 1956		19B. MAJOR FINDINGS OF OPERATION: Multiple myeloma		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1956, to 30 Oct, 1956, that I last saw the deceased alive on 29 Oct, 1956, and that death occurred at 7:35 A.M. from the causes and on the date stated above.

SIGNATURE: Harry A. Horstman, Jr.		ADDRESS: M.D. 1835 Ego St NW Wash DC.		DATE SIGNED: 30 Oct 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 11/2/56		NAME OF CEMETERY OR CREMATORY: Laurel Hill	
LOCATION (City, town, or county) (State): Phila, Pa		24. FUNERAL DIRECTOR: Warner E. Humphrey		ADDRESS: 8434 So Am W	
DATE REC'D BY LOCAL REGISTRAR: 10-30-56		REGISTRAR'S SIGNATURE: Ben M. Thompson			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-56

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 2 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515

CERTIFICATE OF DEATH

10498

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8103 Hampden Lane</u>		d. STREET ADDRESS <u>8103 Hampden Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATE ROY RYLAND</u>		4. DATE OF DEATH Month Day Year <u>Oct. 9, 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>1 1 1</u>	IF UNDER 24 HRS. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorating</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Kate Garrett, Katherine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Percy Ryland- Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Culmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/6/57</u> , 19 <u>57</u> , to <u>10/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/9</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alexander C. Leonardo</u>		DATE SIGNED <u>10/9/56</u>	
PHYSICIAN'S NAME (Type) <u>Alexander C. Leonardo</u>		ADDRESS (Street, city or town, state) <u>5801-13th St., N.W., Wash., D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		ADDRESS <u>Robert A. Pumphrey-Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>10-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

OCT 15 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10499

10420

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D C</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>Takoma Park, Md. 921-Eye NW</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle _____ Last <u>Saris</u>		4. DATE OF DEATH Month <u>October</u> Day <u>II</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/88</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Athanasios Saris</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-12-7620</u>	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO <u>162X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heavy cigarette smoker</u> DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 1948</u> , 19____, to <u>Oct. II</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. II</u> , 19 <u>56</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Oliver E. Thompson, M.D.</u> 1835 Eye Street N. W. Wash. D. C. PHYSICIAN'S NAME (Type) <u>Oliver E. Thompson, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u>		ADDRESS <u>3605-14 St NW Wash. D C</u>	
24a. REC'D BY REGISTRAR <u>10/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING 18

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Oct 11 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>	
EDUCATION <i>High School</i>		RELIGION <i>Catholic</i>		MARRIAGE <i>Married</i>	
SPOUSE <i>John Doe</i>		CHILDREN <i>2</i>		GRANDCHILDREN <i>1</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>Oct 11 1956</i>		DATE OF SIGNATURE <i>Oct 11 1956</i>		DATE OF SIGNATURE <i>Oct 11 1956</i>	
PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>	
CITY <i>Baltimore</i>		CITY <i>Baltimore</i>		CITY <i>Baltimore</i>	
STATE <i>Md</i>		STATE <i>Md</i>		STATE <i>Md</i>	
COUNTRY <i>USA</i>		COUNTRY <i>USA</i>		COUNTRY <i>USA</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>Oct 11 1956</i>		DATE OF SIGNATURE <i>Oct 11 1956</i>		DATE OF SIGNATURE <i>Oct 11 1956</i>	
PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>		PLACE OF SIGNATURE <i>Home</i>	
CITY <i>Baltimore</i>		CITY <i>Baltimore</i>		CITY <i>Baltimore</i>	
STATE <i>Md</i>		STATE <i>Md</i>		STATE <i>Md</i>	
COUNTRY <i>USA</i>		COUNTRY <i>USA</i>		COUNTRY <i>USA</i>	

BUREAU V. S.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10516

CERTIFICATE OF DEATH

10500

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>				d. STREET ADDRESS <u>2048 Garfield Terrace NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roland</u> First <u>Weyburn</u> Middle <u>SCHUMANN</u> Last				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-58 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mariner Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>George SCHUMANN</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte WEYBURN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WW I & II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>SP4 CDR R oland SCHUMANN</u> Address <u>4418 Stanford Street, Chevy Chase, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, anterior cerebral artery</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Oct</u> , 19 <u>56</u> , to <u>9 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 Oct</u> , 19 <u>56</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USNH, NNMC, Bethesda, Maryland</u> DATE SIGNED <u>10-10-56</u> ACTUAL SIGNATURE <u>H.E. RICHARDSON, CAPT, MC, USN</u> M.D. <u>USNH, NNMC, Bethesda, Maryland</u> PHYSICIAN'S NAME (Type) <u>H. E. RICHARDSON CAPT MC USN</u> <u>USNH, NNMC, Bethesda, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey Funeral Home</u> <u>7557 Wisconsin Avenue, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>10 Oct 56</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary E. Parnell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. DATE OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF STATE CLERK		29. SIGNATURE OF FEDERAL CLERK		30. SIGNATURE OF POSTAL CLERK		31. SIGNATURE OF TELEGRAPH CLERK		32. SIGNATURE OF RAILROAD CLERK		33. SIGNATURE OF AIR MAIL CLERK		34. SIGNATURE OF MARINE CLERK		35. SIGNATURE OF NAVY CLERK		36. SIGNATURE OF ARMY CLERK		37. SIGNATURE OF AIR FORCE CLERK		38. SIGNATURE OF SPACE CLERK		39. SIGNATURE OF NUCLEAR CLERK		40. SIGNATURE OF OTHER CLERK	
1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. DATE OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF STATE CLERK		29. SIGNATURE OF FEDERAL CLERK		30. SIGNATURE OF POSTAL CLERK		31. SIGNATURE OF TELEGRAPH CLERK		32. SIGNATURE OF RAILROAD CLERK		33. SIGNATURE OF AIR MAIL CLERK		34. SIGNATURE OF MARINE CLERK		35. SIGNATURE OF NAVY CLERK		36. SIGNATURE OF ARMY CLERK		37. SIGNATURE OF AIR FORCE CLERK		38. SIGNATURE OF SPACE CLERK		39. SIGNATURE OF NUCLEAR CLERK		40. SIGNATURE OF OTHER CLERK	

BUREAU V. 31

OCT 11 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10517

CERTIFICATE OF DEATH

Reg. Dist. No. 218

10501

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 2 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		478-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS 1725 17 th st. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MIRIAN FAIRCHILD SHERMAN		4. DATE OF DEATH Month Day Year OCTOBER 6 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY WYCA	
11. BIRTHPLACE (State or foreign country) Ash Grove, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Sherman		14. MOTHER'S MAIDEN NAME Caroline M. Alvord	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-26-8448	
17. INFORMANT Asbury Home records		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY, 1956 , to OCTOBER, 1956 , that I last saw the deceased alive on OCTOBER 5, 1956 , and that death occurred at 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) DATE SIGNED 4208 Anthony St Kensington, Md. 10-6-56	
PHYSICIAN'S NAME (Type) Sarah E. Glover			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-56	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Carlisle Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel E. Yantner		ADDRESS Gaithersburg Md	
24a. REC'D BY REGISTRAR DATE OCT 9-56		24b. REGISTRAR'S SIGNATURE Alfred L. Cooke	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10502

Reg. Dist. No.

217

10518

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>			
c. LENGTH OF STAY IN 1b <u>1 mo</u>				d. STREET ADDRESS <u>Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Virginia Shirley</u>				4. DATE OF DEATH Month Day Year <u>Oct 14 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>6-12-87</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>100-100-1000</u>		17. INFORMANT <u>John Shirley</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Angioplasty</u> (c) <u>stenting the underlying cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>1 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lewinsville</u>	
22d. LOCATION (City, town, or county) <u>va</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peersons Funeral Home</u>				ADDRESS <u>Fuller Church</u>		24a. REC'D BY REGISTRAR <u>DATE 17 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertude B. Lawler</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

OCT 17 1956

RECEIVED

10519

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMC, Bethesda, Md.</u>		d. STREET ADDRESS <u>212 Monroe Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rochester</u> Middle <u>Ford</u> Last <u>SIMS</u>		4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 April 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Correspondence secretary D.C. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHINA</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Earle David SIMS</u>		14. MOTHER'S MAIDEN NAME <u>Vivia DIVERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>577 07 6525</u>	
17. INFORMANT <u>Mrs. Thelma Mae SIMS, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease with mitral insufficiency</u> DUE TO <u>and tricuspid insufficiency</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Sept.</u> , 19 <u>56</u> , to <u>5 Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Oct.</u> , 19 <u>56</u> , and that death occurred at <u>6:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry A. Schlang</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-6-56</u>	
PHYSICIAN'S NAME (Type) <u>H. A. SCHLANG, CDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Arl. Va</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Funeral Home, 3072 M. St., N.W. Wash.</u>		24a. REC'D BY REGISTRAR <u>DATE 10-5-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Parrelly</u>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. DATE OF BIRTH May 19, 1916		6. PLACE OF BIRTH Jackson, Tennessee	
7. OCCUPATION Minister		8. MARITAL STATUS Single		9. EDUCATION High School	
10. PRESENT ADDRESS 1111 North Broadway, Baltimore, Md.		11. DATE OF DEATH May 23, 1951		12. PLACE OF DEATH Baltimore, Md.	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. MEDICAL HISTORY None	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF DECEASED James Earl Ray	
19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF DECEASED James Earl Ray		21. SIGNATURE OF DECEASED James Earl Ray	

BUREAU V. 3

U.S. DEPT. OF JUSTICE, MAY 11 1951

RECEIVED

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

10421

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp.				d. STREET ADDRESS 1211 Delafield Pl. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Emmett Smith				4. DATE OF DEATH Month October Day 10 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1893		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Bur. of Eng.		10b. KIND OF BUSINESS OR INDUSTRY Pharmacist		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Smith				14. MOTHER'S MAIDEN NAME Rosalie Harman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Emily G. Smith 1211 Delafield Pl. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary DUE TO Cholesterol (c) Parkinson's Syndrome							INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 240X (b) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1 Day	
21. I certify that I attended the deceased from 1954 , 19 10/10/ 19 36 that I last saw the deceased alive on 10/10/ 19 56 , and that death occurred at 7:55 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas H. Wolohan M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 500 Underwood St, NW 10/11/56			
PHYSICIAN'S NAME (Type) Chas H. Wolohan				Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Georgia Ave. N.W.		24a. REC'D BY REGISTRAR DATE 10/13/56	
				24b. REGISTRAR'S SIGNATURE J. H. Deall			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

OCT 17 1956

RECEIVED

TO HOSPITAL: 1. ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10505

10520

CERTIFICATE OF DEATH

Reg. Dist. No.

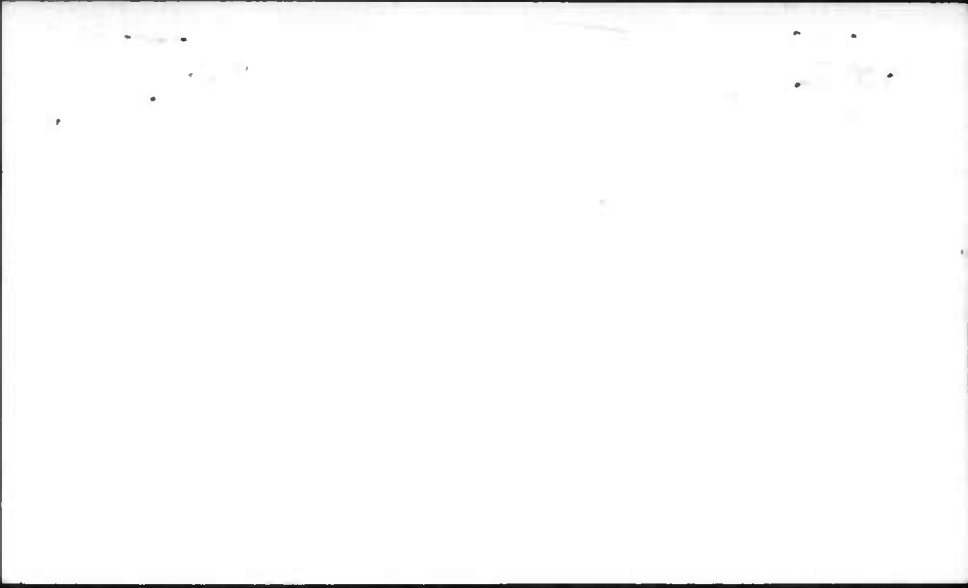
216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 95 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Iva Middle Brown Last Smith		4. DATE OF DEATH Month October Day 4 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 9, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Moriarty		14. MOTHER'S MAIDEN NAME Elizabeth Lanham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 226-48-2242	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, acute 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute leukemic crisis DUE TO (c) Chronic myelogenous leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 1 1/2 - 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956 to October 4, 1956 , that I last saw the deceased alive on October 4, 1956 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jarvis E. Seegmiller M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 10/4/56			
PHYSICIAN'S NAME (Type) Jarvis E. Seegmiller, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16-56	
22c. NAME OF CEMETERY OR CREMATORY Natl. Mem. B. Park		22d. LOCATION (City, town, or county) (State) Fair Church Va	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Deming & Son		ADDRESS 10765c	
24a. REC'D BY REGISTRAR Ben M. Thompson		24b. REGISTRAR'S SIGNATURE Ben M. Thompson	

9561 6 100

TO WHOM IT MAY CONCERN:

Patient requested last name to be changed from:
Iva Brown Gilliland, to Iva Brown Smith, through her
son, prior to death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10506

10521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Diney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hosp-</u>		d. STREET ADDRESS <u>3016-43rd St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Anna</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30 1862</u> 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>W. Winfield N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Lyma Smith</u>		14. MOTHER'S MAIDEN NAME <u>Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>3016-43rd St. N.W. Wash-D.C.</u>	
17. INFORMANT <u>Mrs. Wm R. Vallerie</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 420.0 DUE TO <u>Generalized Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March, 1956</u> to <u>Oct. 9, 1956</u> , that I last saw the deceased alive on <u>October 8, 1956</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charleen G Kirkpatrick</u> M.D.		ADDRESS (Street, city or town, state) <u>1726 Eye St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>CHARLEEN G. KIRKPATRICK, M.D., 1726 Eye St NW, Washington, DC</u>		DATE SIGNED <u>Oct. 9, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Herkimer New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Swales Sons, WASH. D.C.</u>		ADDRESS <u>WASHINGTON, D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 10/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>James Kington</u>	

CERTIFICATE OF DEATH

Montgomery
District of Columbia
Washington
Sharon Chronic Hosp - 3016-43rd St N.W.
Ever Anna Snyder
F W
Housewife
Ruth Smith
Hwy. 30182 24
11-2-A
2016-43rd St N.W. Wash - D.C.
R. Williams
Snyder

BUREAU V. 2

MARCH 25

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10522

CERTIFICATE OF DEATH

Reg. Dist. No. 10507
216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	c. LENGTH OF STAY IN 1b 29 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4613 Langdrum Lane		d. STREET ADDRESS 4613 Langdrum Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles First Henry Middle Squire Last		4. DATE OF DEATH October 16 Month 1956 Day 19 Year 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Judge, Probate Court, Mont. Co.		10b. KIND OF BUSINESS OR INDUSTRY Illinois	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME unobtainable		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Mrs. Charles H. Squire		Address Chevy Chase, Md. 4613 Langdrum Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Asthma DUE TO (c) Emphysema + Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days 1 year Many Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 2 , 19 35 , to Oct 16 , 19 56 , that I last saw the deceased alive on Oct 16 , 19 56 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bradley D. Hodgkins		ADDRESS (Street, city or town, state) 14413 Bradley Lane DATE SIGNED 10/16/56	
PHYSICIAN'S NAME (Type) Bradley D. Hodgkins			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/17/56	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR 40-18-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

9561 22 OCT

RECEIVED

10523

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington, 7</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS NURSING HOME</u>				d. STREET ADDRESS <u>3517 - Davis Street NW</u>			
3. NAME OF DECEASED (Type or print) <u>William Joseph Stanton</u>				4. DATE OF DEATH <u>Oct. 3</u> 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 23, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Stanton</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Prendergast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Walter C. Stanton - Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerosis - family</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/9/56</u> , 19 <u>56</u> , to <u>10/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/2/56</u> , 19 <u>56</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Allen MD</u> M.D.				ADDRESS (Street, city or town, state) <u>Kensington, MD</u>			
DATE SIGNED <u>10/4/56</u>							
PHYSICIAN'S NAME (Type) <u>SAMUEL ALLEN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT. 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SILVER SPRING, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Don. DeVol</u>				ADDRESS <u>2224 - Wis. N.W.</u>		24a. REC'D BY REGISTRAR <u>10-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10/1914

NEWSTON GARDEN, HURSTING HILLS

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BUREAU V.

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RECEIVED

1954-1955

1980-1981

10422

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8519 GLENVIEW AVE.				d. STREET ADDRESS 8519 GLENVIEW AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LeROY Middle B. Last STAPLEFORD				4. DATE OF DEATH Month OCTOBER Day 12 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1911		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METEOROLOGIST, Weather Bureau U. S. GOV'T.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lowell, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST STAPLEFORD				14. MOTHER'S MAIDEN NAME THERESA M. HOWE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. YES		17. INFORMANT Address Mrs. Anna Marie Stapleford, 8519 Glenview Ave. Takoma Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 56 , 19 56 , to Oct 12 , 19 56 , that I last saw the deceased alive on Oct 12 , 19 56 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Raymond O. West 7600 Carroll Ave, Takoma Park, Md							
ACTUAL SIGNATURE Raymond O. West				M.D. 7600 Carroll Ave, Takoma Park, Md			
PHYSICIAN'S NAME (Type) RAYMOND O. WEST							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 10/15/56		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORY NEW PAWTUCKET CEMETERY		22d. LOCATION (City, town, or county) (State) PROVIDENCE, RHODE ISLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 10/15/56	
				24b. REGISTRAR'S SIGNATURE William D. Bell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10510

10524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b Kensington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10614 Wheatley Street				d. STREET ADDRESS 10604 Wheatley Street			
3. NAME OF DECEASED (Type or print) JOSEPH H. STOCKDALE				4. DATE OF DEATH October 26, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1882	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 9 Days 25	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Wool Industry		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (285-07-2979)		17. INFORMANT Margaret A. Stockdale-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aricular fibrillation DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				DATE SIGNED 10/26/56			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/29/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.			24a. REC'D BY REGISTRAR DATE 10/30/56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10511

10525 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
TOWN <u>Kensington</u>		TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>3002 Edgewood Rd</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Evelyn Mudd Stone</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10/27/56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5/24-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Stephen Mudd</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Eliza Lippert</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Miss Evelyn Mudd Stone Daughter</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>331X</u> <u>(a) Cerebral Hemorrhage</u>			
Antecedent cause(s) <u>(b) Arteriosclerosis - Gen'l</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c) Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1950, 19....., to 10/27/56, that I last saw the deceased alive on 10/26/56, and that death occurred at 5:15 A.M. m., from the causes and on the date stated above.

SIGNATURE <u>James M. D. 10/27/56</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>10/30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Wash DC</u>	
DATE REC'D BY LOCAL REG. <u>10/27/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>W. F. Huntman & Son</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5732 Hallam

RECEIVED

NOV 2 1956

BUREAU V. S.

10526

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood				c. LENGTH OF STAY IN 1b 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5221 Kenwood Ave.				d. STREET ADDRESS 5221 Kenwood Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HATTIE Middle C. Last STROBEL				4. DATE OF DEATH Month Oct. Day 28, Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 5, 1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 8 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Rolla, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Benjamin Culbertson				14. MOTHER'S MAIDEN NAME Harriett ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Mrs. J.L. Jerman		Address 5221 Kenwood Ave. Kenwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 157x DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 1, 1956 , to Oct 28, 1956 , that I last saw the deceased alive on Oct 27, 1956 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Robert Perkins		M.D. 1463 Rhode Island Ave., N.W. 10/27/56		ADDRESS (Street, city or town, state) Washington, D.C.		DATE SIGNED 10/27/56	
PHYSICIAN'S NAME (Type) W. Robert Perkins		1463 Rhode Island Ave., N.W. 10-27-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 10-30-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 10-30-56	
				24b. REGISTRAR'S SIGNATURE Rebecca M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10528

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF FUNERAL HOME [Faint text]		NAME OF BURIAL PLACE [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]		SIGNATURE OF BURIAL PLACE [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	
NAME OF WITNESS [Faint text]		NAME OF WITNESS [Faint text]		NAME OF WITNESS [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	
NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF FUNERAL HOME [Faint text]		NAME OF BURIAL PLACE [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]		SIGNATURE OF BURIAL PLACE [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	
NAME OF WITNESS [Faint text]		NAME OF WITNESS [Faint text]		NAME OF WITNESS [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. 3

NOV 1 1956

RECEIVED

10527

CERTIFICATE OF DEATH

10513

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 8115 Riverside Ave	
3. NAME OF DECEASED (Type or print) First Martha Middle Ann Last SWEITZER		4. DATE OF DEATH Month October Day 1 Year 19 56	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1940
9. AGE (In years last birthday) yrs. 16		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alvie Howard SWEITZER		14. MOTHER'S MAIDEN NAME Martha LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Father) Alvie H. Sweitzer (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia (c) Ca. 11 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal septicemia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 23, 1956 , to Oct. 1, 1956 , that I last saw the deceased alive on Oct. 1, 1956 and that death occurred at 7:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-1-56			
ACTUAL SIGNATURE Russell Miller, Jr. M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT.MC.USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-2-56	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR 10-1-56		24b. REGISTRAR'S SIGNATURE Mary E. Carrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 45</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH Jan 5, 1956</p>		<p>PLACE OF DEATH Baltimore, Md.</p>	
<p>CAUSE OF DEATH Coronary Thrombosis</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>	
<p>DATE OF BIRTH Dec 10, 1910</p>		<p>PLACE OF BIRTH Baltimore, Md.</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>	
<p>RELIGION Catholic</p>		<p>MARRIAGE Married</p>	
<p>DATE OF MARRIAGE Jan 15, 1935</p>		<p>NAME OF SPOUSE Mary H. Harris</p>	
<p>DATE OF DEATH Jan 5, 1956</p>		<p>PLACE OF DEATH Baltimore, Md.</p>	
<p>CAUSE OF DEATH Coronary Thrombosis</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>	
<p>DATE OF BIRTH Dec 10, 1910</p>		<p>PLACE OF BIRTH Baltimore, Md.</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>	
<p>RELIGION Catholic</p>		<p>MARRIAGE Married</p>	
<p>DATE OF MARRIAGE Jan 15, 1935</p>		<p>NAME OF SPOUSE Mary H. Harris</p>	

RECEIVED
 JAN 5 1956
 BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No.

216

10528

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4119 Sampson Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Flonnie</u> Middle <u>New</u> Last <u>TENNANT</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-05</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR: Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard K. Tennant</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Arlene Tennant - above</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> 420.1 DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15, 1956</u> to <u>Oct. 15, 1956</u> , that I last saw the deceased alive on <u>Oct. 15, 1956</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Der Rax Ave Bethesda, Md. 10/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		DATE SIGNED <u>10/15/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairfax</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>IN WIL CHAMBERS CO</u>		ADDRESS <u>5801 CLEVELAND AVE</u>	
24. REC'D BY REGISTRAR <u>10/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>James Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 18 1956

BUREAU V. S.

Robert G. Angles

Mrs. A. J. Tennant - Above
Ellis Hughes
South Carolina
A. J. N.

New

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10529

CERTIFICATE OF DEATH

10515

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont 85X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1042½ Morgantown Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Leo Last Truban				4. DATE OF DEATH Month October , Day 1 , Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 1923	
9. AGE (In years lost birthday) 33 yrs.		IF UNDER 1 YEAR Months 1 Days 2 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpet Layer				10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Toby Truban				14. MOTHER'S MAIDEN NAME Nora Paugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 236-32-5439		17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) peripheral shock 2920 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) blood loss DUE TO (c) Familial atypical hemolytic anemia lifelong						INTERVAL BETWEEN ONSET AND DEATH 6 h.	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary bile duct obstruction	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 26, 1956 , to October 1, 1956 , that I last saw the deceased alive on October 1, 1956 , and that death occurred at 7:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rudi Schmid M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 10/2/56	
PHYSICIAN'S NAME (Type) Rudi Schmid, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 10/6/1956		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Fairmont West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR 10-2-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

Robert A. Humphrey-7557 W. 1st Ave. Bethesda, Md.

Re-transit 10/5/1956 Holy Cross

Simon

RECEIVED

OCT 5 1956

BUREAU V. 1

THE OFFICIAL RECORD OF THE
DEPARTMENT OF HEALTH - BALTIMORE, MD.
1956

1. NAME OF DECEASED: Robert A. Humphrey
2. DATE OF DEATH: 10/5/1956
3. TIME OF DEATH: 10:00 AM
4. PLACE OF DEATH: Holy Cross
5. AGE: 75
6. SEX: Male
7. RACE: White
8. BIRTH DATE: 10/5/1901
9. BIRTH PLACE: West Virginia
10. OCCUPATION: Furniture Co.
11. MARITAL STATUS: Single
12. EDUCATION: High School
13. RELIGION: Roman Catholic
14. SOCIAL SECURITY NUMBER: 24-123456789
15. PREVIOUS RECORDS: None
16. SIGNATURE OF DECEASED: [Signature]
17. SIGNATURE OF WITNESS: [Signature]
18. SIGNATURE OF CLERK: [Signature]
19. SIGNATURE OF PHYSICIAN: [Signature]
20. SIGNATURE OF BURIAL OFFICIAL: [Signature]

THE OFFICIAL RECORD OF THE
DEPARTMENT OF HEALTH - BALTIMORE, MD.
1956

1. NAME OF DECEASED: Robert A. Humphrey
2. DATE OF DEATH: 10/5/1956
3. TIME OF DEATH: 10:00 AM
4. PLACE OF DEATH: Holy Cross
5. AGE: 75
6. SEX: Male
7. RACE: White
8. BIRTH DATE: 10/5/1901
9. BIRTH PLACE: West Virginia
10. OCCUPATION: Furniture Co.
11. MARITAL STATUS: Single
12. EDUCATION: High School
13. RELIGION: Roman Catholic
14. SOCIAL SECURITY NUMBER: 24-123456789
15. PREVIOUS RECORDS: None
16. SIGNATURE OF DECEASED: [Signature]
17. SIGNATURE OF WITNESS: [Signature]
18. SIGNATURE OF CLERK: [Signature]
19. SIGNATURE OF PHYSICIAN: [Signature]
20. SIGNATURE OF BURIAL OFFICIAL: [Signature]

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10516

10423

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u> <u>7300 Baltimore Ave.</u>		d. STREET ADDRESS <u>1530 Newton St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise C. Vail</u>		4. DATE OF DEATH Month Day Year <u>October 11 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Colborne</u>		14. MOTHER'S MAIDEN NAME <u>Martha L.----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rest Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Cardiac failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>55</u> to <u>Oct 11</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>56</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis P. Nauman</u> M.D.		ADDRESS (Street, city or town, state) <u>1511-17 St. N.W. Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>1956</u>		DATE SIGNED <u>Oct 11 1956</u>	
22a. BURIAL, CREMATION, REMOVAL <u>burial</u>	22b. DATE THEREOF <u>10/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 10/15/56</u>	24b. REGISTRAR'S SIGNATURE <u>J. E. Hines</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MARYLAND		OCTOBER 17, 1956	
DECEASED'S NAME		LAST NAME	
JOHN J. VAIL		VAIL	
FIRST NAME		JOHN J.	
MIDDLE NAME		J.	
AGE		65	
SEX		MALE	
RACE		WHITE	
RELIGION		CATHOLIC	
MARRIED		YES	
OCCUPATION		FARMER	
EDUCATION		HIGH SCHOOL	
BIRTH DATE		OCTOBER 17, 1891	
BIRTH PLACE		BALTIMORE, MARYLAND	
FATHER'S NAME		JOHN J. VAIL	
MOTHER'S NAME		MARY J. VAIL	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF DEATH REGISTRAR		[Signature]	
SIGNATURE OF WITNESSES		[Signatures]	

BUREAU V. S.

OCT 17 1956

RECEIVED

10424

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>58 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. STREET ADDRESS <u>113 Oxford St., Chevy Chase</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OR DECEASED (Type or print) <u>Elizabeth Hamilton Vance</u>				4. DATE OF DEATH <u>10 - 28 - 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-6-71</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Armstrong</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> 8-10 yrs. (c) <u>GANCRENE LEFT LOWER EXTREMITY</u> 5-6 mos. INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>October 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 27</u> , 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u>				M.D. <u>1352 UNIVERSITY LANE</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				DATE SIGNED <u>NOV 1 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington</u>				(State) <u>D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u>				ADDRESS <u>1756 Pa. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>John Dadd</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>10/31/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10530 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10518

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4120 HARRISON ST. NE	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM C. VAN VLECK		4. DATE OF DEATH Month Day Year October 12 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/1885
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Professor	
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H. VanVleck		14. MOTHER'S MAIDEN NAME MARTHA SHINN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JENNIE VAN VLECK		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 90460 (b) Cardio-Vascular Renal Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 days 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9 27 1956 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Wash. D.C.	
21. I certify that I attended the deceased from Sept. 27, 1956 , to Oct. 12, 1956 , that I last saw the deceased alive on October 12, 1956 , and that death occurred at 9:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sidney E Cousins M.D. 3931 Ingomar Rd NW 10/12/56			
ACTUAL SIGNATURE Sidney E Cousins M.D. 3931 Ingomar Rd NW 10/12/56			
PHYSICIAN'S NAME (Type) SIDNEY E COUSINS Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/15/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Sons		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR 10-15-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

1. NAME OF DECEASED Montgomery		2. SEX Male	
3. AGE 35		4. RACE White	
5. OCCUPATION Professor		6. PLACE OF BIRTH Van Alstede	
7. DATE OF DEATH October 18, 1956		8. PLACE OF DEATH Suburban Hospital	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. SIGNATURE OF WITNESSES J. H. Smith		14. SIGNATURE OF DECEASED J. H. Smith	
15. SIGNATURE OF FUNERAL HOME J. H. Smith		16. SIGNATURE OF BURIAL PLACE J. H. Smith	
17. SIGNATURE OF CEMETERY J. H. Smith		18. SIGNATURE OF INTERMENT J. H. Smith	
19. SIGNATURE OF BURIAL PLACE J. H. Smith		20. SIGNATURE OF INTERMENT J. H. Smith	
21. SIGNATURE OF BURIAL PLACE J. H. Smith		22. SIGNATURE OF INTERMENT J. H. Smith	
23. SIGNATURE OF BURIAL PLACE J. H. Smith		24. SIGNATURE OF INTERMENT J. H. Smith	
25. SIGNATURE OF BURIAL PLACE J. H. Smith		26. SIGNATURE OF INTERMENT J. H. Smith	
27. SIGNATURE OF BURIAL PLACE J. H. Smith		28. SIGNATURE OF INTERMENT J. H. Smith	
29. SIGNATURE OF BURIAL PLACE J. H. Smith		30. SIGNATURE OF INTERMENT J. H. Smith	
31. SIGNATURE OF BURIAL PLACE J. H. Smith		32. SIGNATURE OF INTERMENT J. H. Smith	
33. SIGNATURE OF BURIAL PLACE J. H. Smith		34. SIGNATURE OF INTERMENT J. H. Smith	
35. SIGNATURE OF BURIAL PLACE J. H. Smith		36. SIGNATURE OF INTERMENT J. H. Smith	
37. SIGNATURE OF BURIAL PLACE J. H. Smith		38. SIGNATURE OF INTERMENT J. H. Smith	
39. SIGNATURE OF BURIAL PLACE J. H. Smith		40. SIGNATURE OF INTERMENT J. H. Smith	
41. SIGNATURE OF BURIAL PLACE J. H. Smith		42. SIGNATURE OF INTERMENT J. H. Smith	
43. SIGNATURE OF BURIAL PLACE J. H. Smith		44. SIGNATURE OF INTERMENT J. H. Smith	
45. SIGNATURE OF BURIAL PLACE J. H. Smith		46. SIGNATURE OF INTERMENT J. H. Smith	
47. SIGNATURE OF BURIAL PLACE J. H. Smith		48. SIGNATURE OF INTERMENT J. H. Smith	
49. SIGNATURE OF BURIAL PLACE J. H. Smith		50. SIGNATURE OF INTERMENT J. H. Smith	
51. SIGNATURE OF BURIAL PLACE J. H. Smith		52. SIGNATURE OF INTERMENT J. H. Smith	
53. SIGNATURE OF BURIAL PLACE J. H. Smith		54. SIGNATURE OF INTERMENT J. H. Smith	
55. SIGNATURE OF BURIAL PLACE J. H. Smith		56. SIGNATURE OF INTERMENT J. H. Smith	
57. SIGNATURE OF BURIAL PLACE J. H. Smith		58. SIGNATURE OF INTERMENT J. H. Smith	
59. SIGNATURE OF BURIAL PLACE J. H. Smith		60. SIGNATURE OF INTERMENT J. H. Smith	
61. SIGNATURE OF BURIAL PLACE J. H. Smith		62. SIGNATURE OF INTERMENT J. H. Smith	
63. SIGNATURE OF BURIAL PLACE J. H. Smith		64. SIGNATURE OF INTERMENT J. H. Smith	
65. SIGNATURE OF BURIAL PLACE J. H. Smith		66. SIGNATURE OF INTERMENT J. H. Smith	
67. SIGNATURE OF BURIAL PLACE J. H. Smith		68. SIGNATURE OF INTERMENT J. H. Smith	
69. SIGNATURE OF BURIAL PLACE J. H. Smith		70. SIGNATURE OF INTERMENT J. H. Smith	
71. SIGNATURE OF BURIAL PLACE J. H. Smith		72. SIGNATURE OF INTERMENT J. H. Smith	
73. SIGNATURE OF BURIAL PLACE J. H. Smith		74. SIGNATURE OF INTERMENT J. H. Smith	
75. SIGNATURE OF BURIAL PLACE J. H. Smith		76. SIGNATURE OF INTERMENT J. H. Smith	
77. SIGNATURE OF BURIAL PLACE J. H. Smith		78. SIGNATURE OF INTERMENT J. H. Smith	
79. SIGNATURE OF BURIAL PLACE J. H. Smith		80. SIGNATURE OF INTERMENT J. H. Smith	
81. SIGNATURE OF BURIAL PLACE J. H. Smith		82. SIGNATURE OF INTERMENT J. H. Smith	
83. SIGNATURE OF BURIAL PLACE J. H. Smith		84. SIGNATURE OF INTERMENT J. H. Smith	
85. SIGNATURE OF BURIAL PLACE J. H. Smith		86. SIGNATURE OF INTERMENT J. H. Smith	
87. SIGNATURE OF BURIAL PLACE J. H. Smith		88. SIGNATURE OF INTERMENT J. H. Smith	
89. SIGNATURE OF BURIAL PLACE J. H. Smith		90. SIGNATURE OF INTERMENT J. H. Smith	
91. SIGNATURE OF BURIAL PLACE J. H. Smith		92. SIGNATURE OF INTERMENT J. H. Smith	
93. SIGNATURE OF BURIAL PLACE J. H. Smith		94. SIGNATURE OF INTERMENT J. H. Smith	
95. SIGNATURE OF BURIAL PLACE J. H. Smith		96. SIGNATURE OF INTERMENT J. H. Smith	
97. SIGNATURE OF BURIAL PLACE J. H. Smith		98. SIGNATURE OF INTERMENT J. H. Smith	
99. SIGNATURE OF BURIAL PLACE J. H. Smith		100. SIGNATURE OF INTERMENT J. H. Smith	

RECEIVED

BUREAU V. 3

OCT 18 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10531

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 mos. 26 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				d. STREET ADDRESS U.S. Naval Hosp. (Nurses Qtrs.)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucille Middle Henrietta Last VOSGERAU				4. DATE OF DEATH Month October Day 12 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1909		9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Otto Henry Vosgerau				14. MOTHER'S MAIDEN NAME Margaret Amanda Boettger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT Address (Mother) Mrs. Margaret Vosgerau, Dennison, Iowa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, left kidney 180x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) with metastases DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 April , 19 56 , to October 12 , 19 56 , that I last saw the deceased alive on 12 Oct. , 19 56 , and that death occurred at 0420A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dennison, Iowa DATE SIGNED 10-12-56							
ACTUAL SIGNATURE A. J. Johnson M.D. U.S. Naval Hospital, Bethesda, Md.				PHYSICIAN'S NAME (Type) A. J. JOHNSON, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 Oct. 1956		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Dennison, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave.				24a. REC'D BY REGISTRAR DATE 10-12-56		24b. REGISTRAR'S SIGNATURE May E. Parrelly	

TO MAY BE RETURNED TO THE REGISTRAR BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

10532

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OCTAVIA Middle WARFIELD Last DICKERSON				4. DATE OF DEATH Month OCTOBER Day 18 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/30/05	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 5 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WAITER PRATHER				14. MOTHER'S MAIDEN NAME RACHEL BOYD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pericarditis & Congestive Heart Failure 591x DUE TO Hypertensive Heart Disease (b) Chronic Pericarditis & Congestive Heart Failure DUE TO Chronic Pericarditis & Congestive Heart Failure (c) Chronic Pericarditis & Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-12-56 19 56 , to 10-18 , 19 56 , that I last saw the deceased alive on 10-18 , 19 56 , and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1602 Georgia Ave Silver Spring Maryland DATE SIGNED 10-18-56							
ACTUAL SIGNATURE Morris Perry M.D. 1602 Georgia Ave Silver Spring Maryland							
PHYSICIAN'S NAME (Type) Morris Perry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORY Brooke Grove		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R.L. Snowden ADDRESS Rockville, Md.				24. REC'D BY REGISTRAR 251556 24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYNARD		2. SEX MALE		3. AGE 40		4. DATE OF BIRTH JAN 15 1916		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JUN 15 1940		9. PLACE OF MARRIAGE BALTIMORE, MARYLAND		10. NAME OF SPouse MAYNARD, MARY	
11. DATE OF DEATH OCT 25 1956		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH HOME		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL	
16. SIGNATURE OF PHYSICIAN J. H. SMITH		17. SIGNATURE OF REGISTRAR J. H. SMITH		18. SIGNATURE OF DECEASED MAYNARD		19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	

BUREAU V. B.

OCT 25 1956

RECEIVED

10533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>mmty</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>				c. LENGTH OF STAY IN 1b <i>25 yrs</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Metropolitan Yvone</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nancy</i> Middle <i>Warren</i> Last <i></i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>27</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-22-1891</i>	
9. AGE (In years last birthday) <i>65 yrs.</i>		IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Cyril Francis</i>				14. MOTHER'S MAIDEN NAME <i>Mary Roland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>				16. SOCIAL SECURITY NO. <i></i>			
17. INFORMANT <i>Bruce Thompson, Gaithersburg md</i>				Address <i></i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hypertension 1 yr</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? <i></i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			
20c. TIME OF INJURY Month, Day, Year Hour <i></i> o. m. <i></i> p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i> (County) <i></i> (State) <i></i>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Brosch</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Brosch M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>10/31/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Rose</i>	
				22d. LOCATION (City, town, or county) <i>Gloppers, Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sunden</i>				ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>Oct 31-56</i>	
				24b. REGISTRAR'S SIGNATURE <i>Alfred L. Conner</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		HABITS		DIET	
PATHOLOGICAL FINDINGS		LABORATORY TESTS		RADIOLOGICAL TESTS		OTHER TESTS	
POSTMORTEM FINDINGS		TOXICOLOGICAL TESTS		HISTOLOGICAL TESTS		OTHER TESTS	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE	

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BUREAU V. 2

10534

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle J Last WATKINS		4. DATE OF DEATH Month October Day 10 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 7 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Broadhurst		14. MOTHER'S MAIDEN NAME Eliza Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Flossie Dodson, Daughter		Address Rt. #2 Silver Sp. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept , 19 55 , to Oct 10 , 19 56 , that I last saw the deceased alive on Oct 10 , 19 56 , and that death occurred at 6:15 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE A. F. Thibadeau		ADDRESS (Street, city or town, state) 10111 Colesville Rd. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) A. F. Thibadeau, M.D.		DATE SIGNED 10/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-1956	22c. NAME OF CEMETERY OR CREMATORY Browningsville	22d. LOCATION (City, town, or county) (State) Montgomery Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md	
24a. REC'D BY REGISTRAR 10/22/56		24b. REGISTRAR'S SIGNATURE Frances Tetter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1175

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH CERTIFICATE OFFICE	
NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH MAY 14 1968	
AGE 35		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION BUSINESSMAN		MANNER OF DEATH SUICIDE	
CAUSE OF DEATH FIRE		PLACE OF DEATH BALTIMORE, MD	
DATE OF BIRTH MAY 14 1933		PLACE OF BIRTH BALTIMORE, MD	
MARRIAGE MARRIED		RELATIONSHIP HUSBAND	
SIGNED BY REGISTRAR [Signature]		SIGNED BY DEATH CERTIFICATE OFFICE [Signature]	
DATE MAY 14 1968		TIME 10:00 AM	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10523

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Randolph		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 8 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS General Delivery		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Anna Middle Ruby Last Weese			4. DATE OF DEATH Month October Day 5 Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1908		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sterling Van Pelt			14. MOTHER'S MAIDEN NAME Gertie Hogan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Escheria coli Septicemia DUE TO (c) Hemorrhage base of brain					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept. 27th, 1956 to October 5th, 1956 , that I last saw the deceased alive on October 5th, 1956 , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Howard R. Engel		M.D. The Clinical Center		DATE SIGNED 10/5/56	
PHYSICIAN'S NAME (Type) Howard R. Engel, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-trans	22b. DATE THEREOF 10/5/1956	22c. NAME OF CEMETERY OR CREMATORY Oddfellows	22d. LOCATION (City, town, or county) (State) Elkins West Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557		ADDRESS Wis. Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR 10-6-56	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

212

2. AD

8091 25 0016

Figure 2

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10536

CERTIFICATE OF DEATH

Reg. Dist. No. 10524
216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5614 32nd St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>L.</u> Last <u>WENNER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/1911</u> 1870	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX H. W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Friend - Mr. Pelam</u> Address <u>5924 31st Place N.W. Washington 15, D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Block with Cardiac Arrest</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stokes-Adams Syndrome</u> DUE TO <u>Arteriosclerosis</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>5 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>1951</u> , to <u>Oct 11</u> , 1956, that I last saw the deceased alive on <u>Oct 11</u> , 1956, and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D. <u>3921 Ingomar St. N.W.</u>				DATE SIGNED <u>10/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Wash 15 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>10-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10256

1. NAME OF DECEASED JAMES H. HONG		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH 1911		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH 1956		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. HONG	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF COUNTY CLERK		17. SIGNATURE OF HEALTH OFFICER		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF HEALTH OFFICER		24. SIGNATURE OF REGISTRAR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF FUNERAL HOME		28. SIGNATURE OF COUNTY CLERK		29. SIGNATURE OF HEALTH OFFICER		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF FUNERAL HOME		34. SIGNATURE OF COUNTY CLERK		35. SIGNATURE OF HEALTH OFFICER		36. SIGNATURE OF REGISTRAR	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF FUNERAL HOME		40. SIGNATURE OF COUNTY CLERK		41. SIGNATURE OF HEALTH OFFICER		42. SIGNATURE OF REGISTRAR	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESSES		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF COUNTY CLERK		47. SIGNATURE OF HEALTH OFFICER		48. SIGNATURE OF REGISTRAR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF FUNERAL HOME		52. SIGNATURE OF COUNTY CLERK		53. SIGNATURE OF HEALTH OFFICER		54. SIGNATURE OF REGISTRAR	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES		57. SIGNATURE OF FUNERAL HOME		58. SIGNATURE OF COUNTY CLERK		59. SIGNATURE OF HEALTH OFFICER		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF FUNERAL HOME		64. SIGNATURE OF COUNTY CLERK		65. SIGNATURE OF HEALTH OFFICER		66. SIGNATURE OF REGISTRAR	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESSES		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF COUNTY CLERK		71. SIGNATURE OF HEALTH OFFICER		72. SIGNATURE OF REGISTRAR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF FUNERAL HOME		76. SIGNATURE OF COUNTY CLERK		77. SIGNATURE OF HEALTH OFFICER		78. SIGNATURE OF REGISTRAR	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES		81. SIGNATURE OF FUNERAL HOME		82. SIGNATURE OF COUNTY CLERK		83. SIGNATURE OF HEALTH OFFICER		84. SIGNATURE OF REGISTRAR	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF FUNERAL HOME		88. SIGNATURE OF COUNTY CLERK		89. SIGNATURE OF HEALTH OFFICER		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF COUNTY CLERK		95. SIGNATURE OF HEALTH OFFICER		96. SIGNATURE OF REGISTRAR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF FUNERAL HOME		100. SIGNATURE OF COUNTY CLERK		101. SIGNATURE OF HEALTH OFFICER		102. SIGNATURE OF REGISTRAR	

BUREAU V. E.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
10537 Item 20b Film G206 11-13-50 ams		10525		Reg. Dist. No. 211					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nr. Comas				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's. Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Slidel Rd.				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle Lee Last White				4. DATE OF DEATH Month Oct Day 26 Year 19 56					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/26/ 1936		9. AGE (In years last birthday) 20 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Tree Trimmer		11. BIRTHPLACE (State or foreign country) Maryland W. Va				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter C. White				14. MOTHER'S MAIDEN NAME Effie Thore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Father - Boyds Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden death									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was driver of car that left highway and ran into tree					
20c. TIME OF INJURY Hour 5:15 Min. P. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) nr. Comas Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10/26/56			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-29-56		22c. NAME OF CEMETERY OR CREMATORY Fairview Oak		22d. LOCATION (City, town, or county) (State) Fairbury Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gortner				ADDRESS Fairbury Md.		24a. REC'D BY REGISTRAR DATE Oct 30/56		24b. REGISTRAR'S SIGNATURE Della N. Burdette	

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NOV 2 1956
BUREAU V. E.

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
DEPARTMENT OF HEALTH - BATHING 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. RACE: [illegible]
5. DATE OF BIRTH: [illegible]
6. PLACE OF BIRTH: [illegible]
7. OCCUPATION: [illegible]
8. MARITAL STATUS: [illegible]
9. EDUCATION: [illegible]
10. RELIGION: [illegible]
11. SOCIAL SECURITY NUMBER: [illegible]
12. DATE OF DEATH: [illegible]
13. TIME OF DEATH: [illegible]
14. PLACE OF DEATH: [illegible]
15. CAUSE OF DEATH: [illegible]
16. MANNER OF DEATH: [illegible]
17. SIGNATURE OF EXAMINER: [illegible]
18. SIGNATURE OF WITNESS: [illegible]
19. SIGNATURE OF CORONER: [illegible]
20. SIGNATURE OF JURY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10538 CERTIFICATE OF DEATH

Reg. Dist. No. 217

10526

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josephine Middle Frances Last Williams		4. DATE OF DEATH Month October Day 24 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/62
9a. AGE (In years last birthday) 94		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Lambert		14. MOTHER'S MAIDEN NAME Becky Shull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record (Granddaughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA - RLL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 490x DUE TO (c) 4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23, 19 56 to October 24, 19 56 , that I last saw the deceased alive on October 23, 19 56 , and that death occurred at 1:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED ACTUAL SIGNATURE C. H. Ligon M.D. PHYSICIAN'S NAME (Type) C. H. Ligon, M. D. Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-56	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 4-25-56	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

CERTIFICATE OF DEATH

10032

10032

NAME OF DECEASED Josephine Frances		DATE OF BIRTH October 24, 1906	
PLACE OF BIRTH Montgomery County, Maryland		DATE OF DEATH October 24, 1956	
AGE 50 yrs.		SEX Female	
MARRIAGE Married		RACE White	
EDUCATION High School		OCCUPATION Housewife	
RELIGION Catholic		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
CERTIFICATE OF DEATH 10032		DATE OF DEATH October 24, 1956	

NAME OF DECEASED Josephine Frances		DATE OF BIRTH October 24, 1906	
PLACE OF BIRTH Montgomery County, Maryland		DATE OF DEATH October 24, 1956	
AGE 50 yrs.		SEX Female	
MARRIAGE Married		RACE White	
EDUCATION High School		OCCUPATION Housewife	
RELIGION Catholic		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
CERTIFICATE OF DEATH 10032		DATE OF DEATH October 24, 1956	

RECEIVED
NOV 1 1956
BUREAU A. A.

10539

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>1869 Wyoming Ave., N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Pinkney</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 March 1894</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John P. Frantz</u>		14. MOTHER'S MAIDEN NAME <u>(First name unknown) DENNEAD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Husband) Raleigh C. Williams (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>Carcinoma of lung with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 Aug.</u> , 19 <u>56</u> , to <u>3 Oct.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 Oct.</u> , 19 <u>56</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell Miller, Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-3-56</u>	
PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr., MD</u>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8 Oct. 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE Funeral Home</u>		ADDRESS <u>4th & Mass Ave. N.E. Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>10-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Farrell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10238

1. NAME OF DECEASED JAMES A. TAYLOR		2. SEX Male		3. AGE 65 years		4. RACE White		5. BIRTH DATE 1873		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED AT Baltimore, Md.		8. DECEASED ON Oct 8, 1956		9. DECEASED AT Home		10. DECEASED AT Time		11. DECEASED AT Place		12. DECEASED AT Time	
13. DECEASED AT Place		14. DECEASED AT Time		15. DECEASED AT Place		16. DECEASED AT Time		17. DECEASED AT Place		18. DECEASED AT Time	
19. DECEASED AT Place		20. DECEASED AT Time		21. DECEASED AT Place		22. DECEASED AT Time		23. DECEASED AT Place		24. DECEASED AT Time	
25. DECEASED AT Place		26. DECEASED AT Time		27. DECEASED AT Place		28. DECEASED AT Time		29. DECEASED AT Place		30. DECEASED AT Time	
31. DECEASED AT Place		32. DECEASED AT Time		33. DECEASED AT Place		34. DECEASED AT Time		35. DECEASED AT Place		36. DECEASED AT Time	
37. DECEASED AT Place		38. DECEASED AT Time		39. DECEASED AT Place		40. DECEASED AT Time		41. DECEASED AT Place		42. DECEASED AT Time	
43. DECEASED AT Place		44. DECEASED AT Time		45. DECEASED AT Place		46. DECEASED AT Time		47. DECEASED AT Place		48. DECEASED AT Time	
49. DECEASED AT Place		50. DECEASED AT Time		51. DECEASED AT Place		52. DECEASED AT Time		53. DECEASED AT Place		54. DECEASED AT Time	
55. DECEASED AT Place		56. DECEASED AT Time		57. DECEASED AT Place		58. DECEASED AT Time		59. DECEASED AT Place		60. DECEASED AT Time	
61. DECEASED AT Place		62. DECEASED AT Time		63. DECEASED AT Place		64. DECEASED AT Time		65. DECEASED AT Place		66. DECEASED AT Time	
67. DECEASED AT Place		68. DECEASED AT Time		69. DECEASED AT Place		70. DECEASED AT Time		71. DECEASED AT Place		72. DECEASED AT Time	
73. DECEASED AT Place		74. DECEASED AT Time		75. DECEASED AT Place		76. DECEASED AT Time		77. DECEASED AT Place		78. DECEASED AT Time	
79. DECEASED AT Place		80. DECEASED AT Time		81. DECEASED AT Place		82. DECEASED AT Time		83. DECEASED AT Place		84. DECEASED AT Time	
85. DECEASED AT Place		86. DECEASED AT Time		87. DECEASED AT Place		88. DECEASED AT Time		89. DECEASED AT Place		90. DECEASED AT Time	
91. DECEASED AT Place		92. DECEASED AT Time		93. DECEASED AT Place		94. DECEASED AT Time		95. DECEASED AT Place		96. DECEASED AT Time	
97. DECEASED AT Place		98. DECEASED AT Time		99. DECEASED AT Place		100. DECEASED AT Time		101. DECEASED AT Place		102. DECEASED AT Time	
103. DECEASED AT Place		104. DECEASED AT Time		105. DECEASED AT Place		106. DECEASED AT Time		107. DECEASED AT Place		108. DECEASED AT Time	
109. DECEASED AT Place		110. DECEASED AT Time		111. DECEASED AT Place		112. DECEASED AT Time		113. DECEASED AT Place		114. DECEASED AT Time	
115. DECEASED AT Place		116. DECEASED AT Time		117. DECEASED AT Place		118. DECEASED AT Time		119. DECEASED AT Place		120. DECEASED AT Time	
121. DECEASED AT Place		122. DECEASED AT Time		123. DECEASED AT Place		124. DECEASED AT Time		125. DECEASED AT Place		126. DECEASED AT Time	
127. DECEASED AT Place		128. DECEASED AT Time		129. DECEASED AT Place		130. DECEASED AT Time		131. DECEASED AT Place		132. DECEASED AT Time	
133. DECEASED AT Place		134. DECEASED AT Time		135. DECEASED AT Place		136. DECEASED AT Time		137. DECEASED AT Place		138. DECEASED AT Time	
139. DECEASED AT Place		140. DECEASED AT Time		141. DECEASED AT Place		142. DECEASED AT Time		143. DECEASED AT Place		144. DECEASED AT Time	
145. DECEASED AT Place		146. DECEASED AT Time		147. DECEASED AT Place		148. DECEASED AT Time		149. DECEASED AT Place		150. DECEASED AT Time	
151. DECEASED AT Place		152. DECEASED AT Time		153. DECEASED AT Place		154. DECEASED AT Time		155. DECEASED AT Place		156. DECEASED AT Time	
157. DECEASED AT Place		158. DECEASED AT Time		159. DECEASED AT Place		160. DECEASED AT Time		161. DECEASED AT Place		162. DECEASED AT Time	
163. DECEASED AT Place		164. DECEASED AT Time		165. DECEASED AT Place		166. DECEASED AT Time		167. DECEASED AT Place		168. DECEASED AT Time	
169. DECEASED AT Place		170. DECEASED AT Time		171. DECEASED AT Place		172. DECEASED AT Time		173. DECEASED AT Place		174. DECEASED AT Time	
175. DECEASED AT Place		176. DECEASED AT Time		177. DECEASED AT Place		178. DECEASED AT Time		179. DECEASED AT Place		180. DECEASED AT Time	
181. DECEASED AT Place		182. DECEASED AT Time		183. DECEASED AT Place		184. DECEASED AT Time		185. DECEASED AT Place		186. DECEASED AT Time	
187. DECEASED AT Place		188. DECEASED AT Time		189. DECEASED AT Place		190. DECEASED AT Time		191. DECEASED AT Place		192. DECEASED AT Time	
193. DECEASED AT Place		194. DECEASED AT Time		195. DECEASED AT Place		196. DECEASED AT Time		197. DECEASED AT Place		198. DECEASED AT Time	
199. DECEASED AT Place		200. DECEASED AT Time		201. DECEASED AT Place		202. DECEASED AT Time		203. DECEASED AT Place		204. DECEASED AT Time	
205. DECEASED AT Place		206. DECEASED AT Time		207. DECEASED AT Place		208. DECEASED AT Time		209. DECEASED AT Place		210. DECEASED AT Time	
211. DECEASED AT Place		212. DECEASED AT Time		213. DECEASED AT Place		214. DECEASED AT Time		215. DECEASED AT Place		216. DECEASED AT Time	
217. DECEASED AT Place		218. DECEASED AT Time		219. DECEASED AT Place		220. DECEASED AT Time		221. DECEASED AT Place		222. DECEASED AT Time	
223. DECEASED AT Place		224. DECEASED AT Time		225. DECEASED AT Place		226. DECEASED AT Time		227. DECEASED AT Place		228. DECEASED AT Time	
229. DECEASED AT Place		230. DECEASED AT Time		231. DECEASED AT Place		232. DECEASED AT Time		233. DECEASED AT Place		234. DECEASED AT Time	
235. DECEASED AT Place		236. DECEASED AT Time		237. DECEASED AT Place		238. DECEASED AT Time		239. DECEASED AT Place		240. DECEASED AT Time	
241. DECEASED AT Place		242. DECEASED AT Time		243. DECEASED AT Place		244. DECEASED AT Time		245. DECEASED AT Place		246. DECEASED AT Time	
247. DECEASED AT Place		248. DECEASED AT Time		249. DECEASED AT Place		250. DECEASED AT Time		251. DECEASED AT Place		252. DECEASED AT Time	
253. DECEASED AT Place		254. DECEASED AT Time		255. DECEASED AT Place		256. DECEASED AT Time		257. DECEASED AT Place		258. DECEASED AT Time	
259. DECEASED AT Place		260. DECEASED AT Time		261. DECEASED AT Place		262. DECEASED AT Time		263. DECEASED AT Place		264. DECEASED AT Time	
265. DECEASED AT Place		266. DECEASED AT Time		267. DECEASED AT Place		268. DECEASED AT Time		269. DECEASED AT Place		270. DECEASED AT Time	
271. DECEASED AT Place		272. DECEASED AT Time		273. DECEASED AT Place		274. DECEASED AT Time		275. DECEASED AT Place		276. DECEASED AT Time	
277. DECEASED AT Place		278. DECEASED AT Time		279. DECEASED AT Place		280. DECEASED AT Time		281. DECEASED AT Place		282. DECEASED AT Time	
283. DECEASED AT Place		284. DECEASED AT Time		285. DECEASED AT Place		286. DECEASED AT Time		287. DECEASED AT Place		288. DECEASED AT Time	
289. DECEASED AT Place		290. DECEASED AT Time		291. DECEASED AT Place		292. DECEASED AT Time		293. DECEASED AT Place		294. DECEASED AT Time	
295. DECEASED AT Place		296. DECEASED AT Time		297. DECEASED AT Place		298. DECEASED AT Time		299. DECEASED AT Place		300. DECEASED AT Time	

BUREAU V. S.

OCT 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10540

CERTIFICATE OF DEATH

10528

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1252 Oates Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Booker Middle Taliaferro Last Williamson		4. DATE OF DEATH Month October Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1911
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 47 Days x Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Library Assistant		10b. KIND OF BUSINESS OR INDUSTRY US Government	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Williamson		14. MOTHER'S MAIDEN NAME Hattie Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-20-4749	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LUNGS BILATERAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYELOGENOUS LEUKEMIA + HEMORRHAGE, LUNGS, BILATERAL PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 8, 1956 , to October 25, 1956 , that I last saw the deceased alive on October 25, 1956 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. W. Weiger R. W. Weiger, M.D. PHYSICIAN'S NAME (Type) R. W. WEIGER, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 10-25-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/56	
22c. NAME OF CEMETERY OR CREMATORY incoln		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Ernest Davis		ADDRESS 1432 1/2 N. Market St.	
24a. REC'D BY REGISTRAR DATE 29 1956		24b. REGISTRAR'S SIGNATURE Leslie Thompson	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10541
CERTIFICATE OF DEATH

10529

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3322 Chauncy Place	
3. NAME OF DECEASED (Type or print) First Martha Middle Lee Last Wilson		4. DATE OF DEATH Month October Day 9 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 26, 1909
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 10 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Waitress Work	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bunion Faulkner		14. MOTHER'S MAIDEN NAME Eula Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 245-03-6756	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure 2° to metastatic cancer of breast 170x DUE TO (b) Cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Increased prothrombin time and abnormally low platelet count from widespread metastases		INTERVAL BETWEEN ONSET AND DEATH 10/9/56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29, 1956 , to October 9, 1956 , that I last saw the deceased alive on October 9, 1956 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chester Z. Haverback M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) Chester Z. Haverback, M. D.		DATE SIGNED 10/9/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tr.		22b. DATE THEREOF 10-10-56	
22c. NAME OF CEMETERY OR CREMATORY Elmwood		22d. LOCATION (City, town, or county) (State) Oxford N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR 10-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
10542 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10542 CERTIFICATE OF DEATH

10530
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>8205 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Lewis</u> Middle <u>Wolfson</u> Last				4. DATE OF DEATH <u>Oct.</u> Month <u>24</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1891</u>	
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing store Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mordecai Wolfson</u>				14. MOTHER'S MAIDEN NAME <u>Margola</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ida Wolfson - wife above</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>169X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>42</u> , to <u>Oct 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda</u> DATE SIGNED <u>10/24/56</u>							
ACTUAL SIGNATURE <u>Paul D. Cantor</u>				M.D. <u>1109 Montgomery Lane</u>			
PHYSICIAN'S NAME (Type) <u>B. DANZANSKY & SONS</u>				ADDRESS <u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Cap. Hebrew Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>10/30/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Francis Patten</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN WHITE		SEX F		AGE 82	
DATE OF BIRTH 1875		PLACE OF BIRTH BALTIMORE, MD		DATE OF DEATH 1956	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED MARY ANN WHITE		SIGNATURE OF WITNESS J. H. WHITE		SIGNATURE OF PHYSICIAN J. H. WHITE	
SIGNATURE OF CLERK J. H. WHITE		SIGNATURE OF REGISTRAR J. H. WHITE		SIGNATURE OF JURY J. H. WHITE	

BUREAU V. B.

NOV 2 1956

RECEIVED

10425

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3 Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. & Hospital</u>				d. STREET ADDRESS <u>5919 - 13th St N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>May</u> First <u>Balbenia</u> Middle <u>Wood</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-76</u>	
				9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household duties Own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <u>Austin Lysight</u>				14. MOTHER'S MAIDEN NAME <u>McTEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Daughter & Wash. San & Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Respiratory Failure</u> DUE TO (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebral Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 days</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7 Oct</u> 19 <u>56</u> , to <u>10 Oct</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9 October</u> 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack Crowell</u>				ADDRESS (Street, city or town, state) <u>2025 Eye St, N.W. Wash, D.C.</u>			
DATE SIGNED <u>10 Oct 56</u>							
PHYSICIAN'S NAME (Type) <u>JACK CROWELL MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner & Pomphrey</u>				ADDRESS <u>8434 Sh. Ave. Silver Spring</u>		24a. REC'D BY REGISTRAR <u>J. Nelson Dodd</u>	
				DATE <u>10/13/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 17 1956

RECEIVED

10543

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 72 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. STREET ADDRESS 1346 Pennsylvania Ave., S. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arlie		First (none) Middle Woodring Last		4. DATE OF DEATH October 24,		Day 19 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Inspector		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Zenas W. Woodring				14. MOTHER'S MAIDEN NAME Ella Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-01-0008		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 190X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant melanoma metastatic to Brain Lung etc. DUE TO (c) 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 13, 1956 to October 24, 1956 , that I last saw the deceased alive on October 24, 1956 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/25/56 ACTUAL SIGNATURE Thomas Waldmann M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Thomas Waldmann, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Smithland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 517-11th St. S.E.		24a. REC'D BY REGISTRAR 40-29-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED Thomas W. Woodson		AGE 72 years		SEX Male		RACE White		DATE OF DEATH January 22, 1956		PLACE OF DEATH Home	
RESIDENCE 1100 Pennsylvania Ave., N.E., Washington, D.C.		DATE OF BIRTH April 10, 1884		MARRIAGE Married		OCCUPATION Retired		EDUCATION High School		RELIGION Roman Catholic	
CAUSE OF DEATH Coronary artery disease		MANNER OF DEATH Natural		PERMANENT DAMAGE None		TEMPORARY DAMAGE None		POST-MORTEM EXAMINATION Not performed		SIGNATURE OF PHYSICIAN J. B. Johnson, M.D.	
SIGNATURE OF DECEASED Thomas W. Woodson		SIGNATURE OF NEXT OF KIN Mrs. Woodson		SIGNATURE OF WITNESS J. B. Johnson, M.D.		SIGNATURE OF REGISTRAR J. B. Johnson, M.D.		SIGNATURE OF CLERK J. B. Johnson, M.D.		SIGNATURE OF JURY J. B. Johnson, M.D.	

BUREAU V. S.

OCT 31 1956

RECEIVED

10426

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> ✓ MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days 10hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Of Columbia</u> 47x-3			
e. STREET ADDRESS <u>6202 7th St. N.W.</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Francis</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-I-02</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Supt.</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Edward Wright</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WWI Navy</u>		17. INFORMANT <u>Hospital Records</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carc L Lungs</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial & pulmonary emboli</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 Mths to Yr</u> <u>3-4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Last 3 yrs.</u> to <u>10/24/1956</u> , that I last saw the deceased alive on <u>10/23/1956</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H. W. Lohman</u> M.D.				DATE SIGNED <u>500 Underwood St. N.W. 10</u>			
PHYSICIAN'S NAME (Type) <u>Chas H. W. Lohman</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home 4812 9th Ave. N.W.</u>				24. REC'D BY REGISTRAR <u>10/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Deaf</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

